

Annual Report

for the year ended 30 June 2016

Ministry of Health

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MANATŪ HAUORA



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Director-General's overview

The Ministry of Health, as steward of the New Zealand health and disability system, is resolutely focused on realising our goal for all New Zealanders to live well, stay well and get well. We understand the influence health has on quality of life and strive for all New Zealanders to have the best possible health outcomes to contribute to a healthy, happy and productive country.

The 2015/16 year can be characterised as one of great transformation for the health and disability system. In April 2016 the Minister of Health, Hon Dr Jonathan Coleman, launched a refreshed New Zealand Health Strategy which builds on the achievements of the previous health strategy, developed 16 years prior. The New Zealand Health Strategy 2016 provides a new high-level direction for New Zealand's health system over the next 10 years within five themes – people powered, closer to home, value and high performance, one team and smart system.

The strategy is the result of extensive consultation throughout New Zealand and I would like to take this opportunity once again to thank all of those who participated.

To be better placed to lead the health and disability system through this period of change and innovation, the Ministry of Health also commenced a transformation programme in 2015/16. Ministry on the Move is a five-year programme that will transform the Ministry into a flexible, focused, connected and collaborative, high-performing organisation that effectively leads and shapes the health and disability system.

I am pleased to say that, while there has been significant focus on the future direction of the health and disability system, the Ministry has also achieved good results in delivering current government priorities and meeting system needs, as demonstrated in this annual report.

Our achievements in the past year have been made possible through the commitment and professionalism of people across the health and disability system, and our colleagues across the social sector and wider government, all of whom work to improve, promote and protect the health of our people so that All New Zealanders can live well, get well and stay well.

Reflecting on last year's achievements, I am encouraged by the progress we have made in improving New Zealanders health outcomes, as measured against the Government's health targets and international comparators. This year we have established our focus on using and sharing information for better outcomes across government, we are building on our approaches to make the best use of new technology, and have reaffirmed our commitment to working across the public sector to make the most positive impact on people's lives. The development of a package of initiatives to combat rising prevalence of childhood obesity was a particular highlight and I look forward to seeing the impacts of its implementation on the lives of many people.

The New Zealand Health Strategy provides a clear direction for the next 10 years and I believe we have a great foundation on which to achieve even better health outcomes for New Zealanders.

Ora pai, pai noho, te tiki pai.

A handwritten signature in black ink, consisting of several loops and a long horizontal stroke extending to the left.

Chai Chuah
Director-General of Health

Contents

Director-General's overview	iii
The Ministry's year in review	1
Strategic direction	4
The Government's priorities	4
Delivering the Government's cross-sector priorities	7
The health targets	12
Implementing the Minister's strategic priorities	21
Other Ministry priorities	35
Achieving our objectives	38
Overview of the Ministry's outcomes framework	38
Health and disability system outcomes	39
The Ministry of Health's high-level outcomes	41
Statement of performance	53
Introduction	53
Health sector information systems	54
Managing the purchase of services	56
Payment services	59
Regulatory and enforcement services	62
Sector planning and performance	66
Policy advice and ministerial servicing	70
Statement of responsibility	72
Independent auditor's report	73
Section 2: Financial statements	79
Statement of budgeted and actual expenses and capital expenditure against appropriations for the year ended 30 June 2016	79
Statement of comprehensive revenue and expense for the year ended 30 June 2016	82
Statement of movements in equity for the year ended 30 June 2016	83
Statement of financial position as at 30 June 2016	84
Statement of cash flows for the year ended 30 June 2016	85
Statement of commitments as at 30 June 2016	86
Notes to the financial statements for the year ended 30 June 2016	87
Non-departmental statements and schedules for the year ended 30 June 2016	105
Statement of non-departmental expenses and capital expenditure against appropriations for the year ended 30 June 2016	105

Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2016	106
Schedule of non-departmental assets and liabilities as at 30 June 2016	107
Schedule of non-departmental commitments as at 30 June 2016	108
Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2016	108
Problem Gambling Levy Report for the year ended 30 June 2016	109
Statement of trust monies for the year ended 30 June 2016	109
Statement of non-departmental unappropriated expenses and capital expenditure for the year ended 30 June 2016	110
Notes to the non-departmental statements and schedules	111
Organisational health and capability	115
Developing our story	115
Recruitment and retention	115
People and capability enhancement	115
Equal employment opportunities	116
Information technology (IT)	116
Procurement strategy	117
Property management	117
Business continuity	118
Managing risk	118
Assurance	119
Emergency management	119
Departmental capital and asset management intentions	120
Additional information	121
Additional statutory reporting requirements	121
Health Act 1956	121
New Zealand Public Health and Disability Act 2000	121
Public Finance Act 1989	121
Other legislation	121
References	122
Appendix A: Legal and regulatory framework	123
Appendix B: Section 11 committees	125
Appendix C: Organisational structure	128
Appendix D: Staff information	130
Appendix E: Staff location	135

List of tables

Table 1: Six health targets for 2015/16	12
Table 2: Health target results for DHBs, by quarters for 2015/16	13
Table 3: Selected New Zealand Health Survey indicators: unadjusted prevalence (%)	43
Table 4: Summary of service performance measures, by departmental expense appropriation	53
Table 5: Summary of output performance measures and standards for health sector information systems	54
Table 6: Financial performance for health sector information systems	55
Table 7: Summary of output performance measures and standards for managing the purchase of services	56
Table 8: Financial performance for managing the purchase of services	58
Table 9: Summary of output performance measures and standards for payment services	59
Table 10: Financial performance for payment services	61
Table 11: Summary of output performance measures and standards for regulatory and enforcement services	62
Table 12: Financial performance for regulatory and enforcement services	65
Table 13: Summary of output performance measures and standards for sector planning and performance	66
Table 14: Financial performance for sector planning and performance	69
Table 15: Summary of output performance measures and standards for policy advice	70
Table 16: Financial performance for policy advice	71
Table 17: People capability measures	116

List of figures

Figure 1: Percentage of patients admitted, discharged or transferred from an emergency department within six hours, 2009/10–2015/16	14
Figure 2: Volume of elective surgery, 2007/08–2015/16	15
Figure 3: Percentage of patients receiving their first cancer treatment within the target timeframe, quarter two 2014/15 to 2015/16	16
Figure 4: Percentage of eight-month-olds fully immunised, 2012/13–2015/16	17
Figure 5: Percentage of smokers offered help to quit, 2009/10–2015/16	18
Figure 6: Percentage of cardiovascular risk assessments completed, Quarter three 2011/12–2015/16	20
Figure D1: Staff FTEs and headcounts, by business unit	130
Figure D2: Staff numbers, by length of service	131
Figure D3: Staff ethnicity	131
Figure D4: Staff numbers, by age group and gender	132
Figure D5: Gender proportion, by age group	132
Figure D6: Staff numbers, by salary band	133
Figure D7: Gender proportion, by salary band	134
Figure E1: Staff location	135

The Ministry's year in review

The 2015/16 year has seen considerable activity by the Ministry of Health and the wider health and disability sector to implement the Government's priorities and ensure accessible, safe, individual- and family-centred, clinically effective and cost-effective health services.

Over 2015/16 the Ministry continued to fulfil its core function of seeking to improve the health and wellbeing of New Zealanders through:

- leading New Zealand's health and disability system
- advising the Minister of Health, and government, on health and disability issues
- purchasing a range of national health and disability support services
- providing health sector information and payment services for the benefit of all New Zealanders.

Contributing to government priorities

The Ministry has contributed to the Government's priorities by working with other agencies to:

- deliver Better Public Services in a challenging fiscal environment
- responsibly manage the Government's finances
- supporting the Christchurch rebuild
- building a more competitive and productive economy.

Delivering the Government's cross-sector priorities

The Ministry worked across government on a number of initiatives in the health and social sector.

- Supporting vulnerable children, including reducing rheumatic fever cases among children, establishing 'sore throat clinics' and contributing to the Children's Action Plan.
- Actively participating in the social sector trials.
- Undertaking activities to support the Prime Minister's Youth Mental Health Project.
- Working with Te Puni Kōkiri and other Ministries to deliver the Whānau Ora approach among service providers, and to progress the Whānau Ora Outcomes.
- Putting a new National Drug Policy in place.

Health Targets

Over the past year, we have continued to make steady progress towards meeting the government's health targets. Both the 'Improved access to elective surgery' and 'More heart and diabetes checks' health targets were met in each quarter of 2015/16. The 'More heart and diabetes checks' health target result of 91 percent in the final quarter represents a notable increase from 46 percent in 2012, when the target first began.

Quarter four results for the 'Shorter stays in emergency departments', 'Increased immunisation' and 'Better help for smokers to quit' targets are all two percent or less from their respective target goals. Results for the 'Faster cancer treatment' target have improved compared with

2014/15, however, we recognise that further improvement will be required to meet our target goal in 2016/17.

Implementing the Minister's strategic priorities

The Ministry continued to implement the Minister's strategic priorities, including:

- making the best use of information technologies and ensuring the security of patient records
- making services more accessible, including more care closer to home
- maintaining wellness for longer by improving prevention
- bowel screening
- reducing obesity and implementing a diabetes plan
- improving the quality and safety of health services
- supporting the health of older people
- implementing Rising to the Challenge
- Smokefree Aotearoa New Zealand 2025 (including the plain packaging amendment bill)
- Therapeutic products regulatory regime
- strengthening the health and disability workforce
- supporting regional and national collaboration.

Other Ministry priorities

The Ministry worked on a number of priorities in the health and social sector, including:

- Māori health research
- Pacific Innovation Fund
- Maternal and child health
- Oral health.

The New Zealand Health Strategy

As part of meeting its priorities, the Ministry released the 2016 New Zealand Health Strategy, which sets the direction for health services to improve the health of people and communities. It provides a road map for the health and disability system over five years to make the Strategy happen. The Strategy aims for all New Zealanders to live well, stay well and get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and where the sector works as one team in a smart system.

Improved health outcomes

This annual report shows that our health system performs well: there has been an increase in the number of years a person can expect to live in good health and, overall, New Zealanders are living longer than ever before. New Zealand also performs well internationally with respect to life expectancy by health spending per capita: it has relatively high life expectancy for comparatively modest health expenditure.

The mortality rate, from those conditions which reflect variations in the cover and quality of health care (preventive or therapeutic services) delivered to individuals, has decreased by 29 percent over the last 10 years (from 132.0 per 100,000 people aged 0–74 years in 2004 to 93.5 per 100,000 in 2013). The decrease was evident across all ethnic groups.

Better use of technology and information

The Ministry focused on using information in a smarter way to gain a better understanding of the wider costs and outcomes associated with health conditions and health service use and improve delivery of services to populations at risk of poor social outcomes. The Ministry currently contributes data from 15 National Collections to the government's Integrated Data Infrastructure (IDI) and embarked on a multiyear research programme to learn more about the relationship between people's health and social outcomes, and the health profiles of priority populations. Work has also been accelerated on the Digital Health Work Programme to improve outcomes for New Zealanders through the smart use of digital health solutions. Initiatives include the establishment of a single electronic health record (EHR).

Ministry on the Move

In 2015 the Ministry began a programme of change. Ministry on the Move will position the Ministry to implement the New Zealand Health Strategy and is designed to:

- strengthen the Ministry's leadership and performance
- create a more agile organisation
- establish a more outcome focused and collaborative approach to the Ministry's role in the health and disability system.

The programme will be delivered over five years.

Strategic direction

The improved wellbeing and health of New Zealanders is being achieved by delivering health services that are accessible, safe, individual- and family-centred, clinically effective and cost-effective. The Ministry has multifaceted strategies, as is appropriate for a complex organisation with complex sector requirements.

The Government's priorities

Delivering Better Public Services in a challenging fiscal environment

Supporting vulnerable children

The cross-government action plan to reduce household crowding and rheumatic fever is part of the Government's commitment to Better Public Services. It contributes to a target to reduce first-incidence rheumatic fever by two-thirds by June 2017.

An updated action plan was agreed by Social Sector Board chief executives in August 2015, and quarterly reports on progress are made to the board's deputy chief executives. An investment case on healthy housing interventions was developed in the second half of 2015 as part of the Social Sector Investment Change Programme's focus on an identified at-risk zero to five years priority population. This investment case proposed to expand the Healthy Homes Initiatives model to populations other than families with children at risk of rheumatic fever.

Investment cases

Investment cases were developed for the cross-agency social sector work programme to meet the Better Public Services 1 target. These looked at early interventions to reduce the impacts of health conditions on employment, and interventions to reduce welfare dependence. These investment cases are being considered as part of the budget process.

Increasing immunisation rates for infants

The Ministry is responsible for a cross-government programme to achieve the Better Public Services result of increased immunisation: the target is for 95 percent of infants receiving their primary course of immunisation on time, maintained through to 30 June 2017. In the fourth quarter of 2016, 92.8 percent of eight-month-olds were fully immunised. When coverage for the primary series of vaccines is measured at age 12 months rather than eight months, the coverage rate is 94.4 percent. This shows that the target can be met if timeliness of immunisation is addressed by immunisation services.

Procurement strategy

The Ministry continues to support the Government Procurement Reform Programme to ensure the procurement of social-sector contracting is more effective and efficient and aligns with the Government's Better Public Services priorities. The Ministry is engaged in all-of-government and cross-agency activities, which involves significant partnership with our colleagues in the Ministry of Social Development; Ministry of Business, Innovation and Employment; The Treasury; and other agencies.

Responsibly managing the government's finances

The Ministry is ensuring that government finances are managed responsibly with other organisations, including ACC and Health Partnerships Limited, as follows.

- Accident Compensation Corporation (ACC): the Ministry works with ACC to develop the annual agreement between the Minister of Health and the Minister for ACC for the ACC public health acute services. The 2015/16 agreement was approved and the 2016/17 agreement is awaiting final approval between the two ministries.
- Health Partnerships Limited: New Zealand Health Partnerships Limited (NZHPL) is a multi-parent Crown entity subsidiary that is supported and owned by New Zealand's 20 district health boards (DHBs). The Ministry has closely supported this organisation through its transition at an organisational governance level, as well as in progressing NZHPL's shared services work programme (including food services, linen and laundry, the National Infrastructure Plan and the National Oracle Solution).

The Ministry is ensuring that government finances are managed responsibly within the Ministry through its work in the following two areas.

Single national residential pricing tool

Disability Support Services continues to work on a business case to move to a single national residential pricing tool. KPMG was contracted by the Ministry to undertake an analysis, which will now be used to form the basis of a funding proposal. This single model will result in national consistency, transparency and equity in residential funding across all providers. This work programme will continue into the 2016/17 financial year.

Pharmacy Action Plan

The Pharmacy Action Plan was launched in June 2016. This five-year plan provides the foundation for delivering integrated pharmacy services across a broader range of settings. It signals the intention to make best use of the capacity and capability of the pharmacy workforce, particularly in medicines management. It also outlines how pharmacists, other health practitioners, funders, key organisations and the Ministry will work together to support transformation, innovation and new integrated models of care.

Supporting the Christchurch rebuild

Hospital redevelopment programme

In 2015/16 the Ministry continued to support Canterbury DHB on the hospital redevelopment programme through the Hospital Redevelopment Partnership Group.

- The \$215 million Burwood Hospital redevelopment was completed in 2016.
- Construction is well under way on the \$481 million acute services building at Christchurch Hospital. The new building is expected to open in 2018.

Design work of the Grey Base Hospital redevelopment has been completed for the \$78 million outpatients' facility. Blessing of the site and ground breaking occurred in July 2016. The new facility is expected to be completed by 2018.

Canterbury mental health package (\$20 million)

The Government is providing an extra \$20 million over the next three years to increase mental health support for people in Canterbury. The package of initiatives will boost current mental health services in Canterbury and includes an extra 26 full-time equivalent (FTE) primary care and community-based mental health workers, as well as further funding for programmes such as telehealth and workforce wellbeing support.

The Government is also in discussions with Christchurch City Council to establish a Crown–Council Partnership Fund to support community-led psychosocial wellbeing and resilience. The Government has agreed to provide up to \$1 million a year for the next three years in match funding, which could be allocated via the Christchurch Earthquake Mayoral Relief Fund.

In addition to the \$20 million package, the Ministry will extend the All Right? campaign for a further three years from 2016/17. The All Right? campaign is designed to help Cantabrians think about their mental health and ways they can improve it. It plays an important role in the wider psychosocial recovery effort.

Canterbury Earthquake Recovery Authority (CERA)

In December 2015 the Canterbury Earthquake Recovery Authority (CERA) and the Department of the Prime Minister and Cabinet (DPMC) began transitioning the responsibility for psychosocial recovery in Canterbury to the Ministry and Canterbury DHB. This process was completed in April 2016. The Ministry is now the accountable agency for psychosocial recovery in Canterbury, with Canterbury DHB responsible for local governance and activity. Oversight is provided by a cross-agency governance group, chaired by the DHB. The ongoing recovery process will be reported in the Canterbury Wellbeing Index. The Minister of Health and DPMC will receive quarterly progress reports.

Enabling Good Lives

The Ministry has a significant role in the Enabling Good Lives (EGL) programme, which provides disabled people with greater choice and control over their supports and lives. The Ministries of Health, Education and Social Development are working together to better support people with a disability. This will be achieved through pooled funding and joint oversight of the EGL work, which in Christchurch focuses on school leavers. The work is supported by a local leadership group and a national leadership group (which also oversees the work of EGL Waikato). Project evaluations have shown that the demonstration is making a real difference to the lives of Christchurch school leavers.

Flexible disability support has recently been introduced as part of the EGL Christchurch demonstration. People using flexible disability support have self-direction over the extent to which they are supported and can receive as much, or as little, assistance as they require to manage their supports. This demonstration is moving into its next phase, which will be led by the Ministry.

Building a more competitive and productive economy

Improved regulatory environment

The Ministry has been actively trying to improve the regulatory environment for natural health and therapeutic products. The objective is to ensure the rules applying to these products are risk-based and cost-effective, so that safe products can be marketed with minimal compliance

costs. In the case of natural health products, an effective regulatory environment that is credible with international trading partners will enable New Zealand producers to export to a wide range of countries.

Trans-Pacific Partnership

The Ministry has been heavily involved in the negotiations leading up to the signing of the Trans-Pacific Partnership, a trade deal that is expected to be of considerable importance to the New Zealand economy. The Ministry's focus has been on ensuring that key aspects of the health system (such as the ability of Pharmac to parallel import drugs and purchase generic drugs) are protected, because they are integral to delivering high-quality health services cost-effectively.

Delivering the Government's cross-sector priorities

The Ministry works across government on a number of initiatives in the health and social sector, including:

- supporting vulnerable children, which includes reducing rheumatic fever cases and assaults on children
- social sector trials
- the Prime Minister's Youth Mental Health project
- Whānau Ora
- National Drug Policy.

Supporting vulnerable children

A substantial reduction in rheumatic fever cases among children

Rheumatic fever primarily affects children and is a complication of a particular type of sore throat (caused by the Group A streptococcal bacteria). It is a preventable disease that can have serious consequences (such as the development of rheumatic heart disease) if not treated early. There are around 140 deaths from rheumatic heart disease in New Zealand each year. Rheumatic fever mainly affects Māori and Pacific people.¹

The Ministry's Rheumatic Fever Prevention Programme contributes to the achievement of the Government's specific rheumatic fever targets.² The Programme targets areas of New Zealand with the highest rates of rheumatic fever hospitalisation, and results currently show a 37 percent decrease in first-episode rheumatic fever hospitalisations since the target was introduced in 2012. A transition to business as usual in DHBs will have taken place by the Programme's end in June 2017.

The Rheumatic Fever Prevention Programme will continue to work with the high-incidence DHBs to deliver a range of initiatives for each of the following three key strategies:

- increasing awareness of rheumatic fever, what causes it and how to prevent it

¹ Acute rheumatic fever is 23 times more likely in Māori and nearly 50 times more likely in Pacific peoples than in other ethnic groups. From 1996 to 2005, while acute rheumatic fever rates significantly decreased among the European population rates among Māori and Pacific children increased significantly.

² To reduce the incidence of rheumatic fever by two-thirds to 1.4 cases per 100,000 people by June 2017.

- improving access to timely, effective treatment for Group A streptococcal sore throat in primary care and community settings
- reducing household transmission of Group A streptococcal bacteria.

The Programme is working with each high-incidence DHB to ensure investment in rheumatic fever prevention continues at the end of the formal programme and to transition them to a sustainable and effective programme after June 2017.

Rapid response clinics

Rapid response clinics, also known as ‘sore throat clinics’, have been established in all 11 DHBs with a high incidence of rheumatic fever. In July 2015 the Ministry contracted an independent formative evaluation of the sore throat clinic services. The evaluation took place during August and September 2015 and identified areas for improvement, which DHBs are working on.

Reducing the number of assaults on children

The Ministry continues to support the health sector’s contribution to the Children’s Action Plan. The Plan provides a framework for how health, education, Police, justice, social services and communities can improve outcomes for vulnerable children and their families. It includes a summary of actions and a five-year timeline (to the end of 2017) of implementation.

There are now 10 children’s teams operating around the country: in Rotorua, Whangarei, Horowhenua, Marlborough, Hamilton, Tairāwhiti, Eastern Bay of Plenty, Whanganui, Canterbury and Counties Manukau. Children’s teams operate at the local level to improve outcomes for children at risk of maltreatment.

Children’s teams are made up of experienced and senior professionals from various agencies and non-governmental organisations (NGOs), who bring their services together into one personalised plan for each child and their family/whānau.

Social sector trials

Social sector trials aim to drive innovation in the health system. They test the potential for improved outcomes by transferring the control of resources (including funding, decision-making authority and accountability for results) from government agencies to a trial lead in the local community.

The Ministry has continued to actively participate in the trials. In June 2016 Cabinet made the decision to transition the successful trials to a community-led model by 31 December 2016. The successful trials that will transition to a locally led model are: South Waikato, Waitomo, Taumarunui, Kawerau, Horowhenua, Porirua, South Dunedin, Gore, Gisborne, Kaikohe and Ranui. The other five trials (Whakatane, Rotorua, Waikato, South Taranaki and Wairarapa) will begin finishing from 1 July 2016.

The Government is considering a new initiative, the ‘place-based approach’, in Northland, Tairāwhiti and South Auckland; the Gisborne and Kaihoke trials are likely to be included in this new community-based approach, which Cabinet is expected to make a decision on in July 2016.

The Prime Minister's Youth Mental Health Project

The Prime Minister's Youth Mental Health Project (YMHP) is a four-year cross-agency project involving the Ministries of Health (as lead agency), Education and Social Development, Te Puni Kōkiri and the Education Review Office. The project aims to improve mental health and wellbeing for young people with, or at risk of developing, mild to moderate mental health issues. The YMHP is a practical example of the social sector working together to deliver improved outcomes for vulnerable populations and to develop a more robust evidence base for which interventions, or groups of interventions, are most effective.

The YMHP has sought to deliver concrete action through a programme expanded over time to 26 initiatives. The YMHP was set up with an explicit aim to build the evidence base for youth mental health. To achieve this, the project has benefited from a comprehensive evaluation programme. June 2016 marks the four-year milestone for the project, with a final evaluation report due in August 2016.

In 2015/16 the Ministry undertook the following YMHP activities.

- Following the Ministry of Education 2014/15 review of school decile ratings, the Ministry expanded school-based health services to include new decile 3 schools while continuing to fund services for those schools that had moved out of decile 3. This means that those services are available to around 55,000 students.
- The Ministry has published case studies about quality improvement initiatives in school-based health services. The case studies provide ideas for nurses, schools, DHBs and others to improve students' health.

The Ministry has also:

- provided health professionals with continued access to training in HEEADSSS³ wellness checks via the online learning module
- continued delivery of the e-therapy tool SPARX, with 7803 users registered with the website since the e-therapy tool was launched in April 2014 and good coverage of health and education providers participating
- improved the number of 12–19-year-olds being seen by primary mental health services across New Zealand – this increased from 7500 in 2013/14 to approximately 14,900 in 2015/16
- supported DHBs to set up youth service-level alliance teams and improve the responsiveness of primary health care services to young people
- exceeded its national wait-time target (80 percent), with nationally 87.3 percent of 12–19-year-olds who contact a youth alcohol and drug service being seen within three weeks (data from 1 April 2015 to 31 March 2016)
- continued to support DHBs to have transition plans in place for children and youth exiting specialist services and to implement exemplar youth alcohol and other drugs (AOD) and co-existing mental health services in pilot areas
- assisted Canterbury DHB to implement the Christchurch Youth Mental Health Action Plan, with over 100 Canterbury schools engaged with the school-based mental health team to address emerging mental health issues in Canterbury.

³ HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety) assessment allows for early identification of mental health, alcohol and other drug (AOD) issues and other information to assist young people in their development.

Whānau Ora

The Ministry works with Te Puni Kōkiri (the lead government agency) and the Ministries of Finance, Education, Social Development, and Economic Development to deliver the Whānau Ora approach among service providers, and to progress achievement of Whānau Ora short-term outcomes as part of the Whānau Ora Outcomes Framework. The health sector approach requires strong engagement from DHBs, which are the most substantial funders of Whānau Ora.

The Ministry supports the Minister of Health's attendance at the Whānau Ora Partnership Group meetings, where iwi chairs and Ministers come together regularly to set the direction for Whānau Ora and oversee the progress and success of Whānau Ora.

In 2015/16 the Ministry:

- continued to publish regular analysis of the performance of general practices involved in Whānau Ora collectives
- worked with DHBs to support their planning responses to contribute to improved health equity for Māori and Pacific people, including preparing DHBs to deliver a heightened focus on five key areas that contribute to Whānau Ora: mental health, asthma, oral health, obesity and tobacco
- implemented a Whānau Ora information system, Mahere, to support planning and track progress against whānau goals; a number of Whānau Ora provider collectives have been trained and are using the system.

The performance of general practices in Whānau Ora collectives is demonstrated in a regular monitoring report, released quarterly, which reports on 11 indicators that are strongly linked to major causes of morbidity and mortality for Māori (Ministry of Health 2016b).

National Drug Policy

Alcohol and drug issues are significant not only for the health system but also across the wider range of issues the Government is seeking to address. For instance, these issues are closely linked with social factors such as income, employment, housing and education, and they are a major issue for the justice system. Effective intervention requires a cross-agency response.

The expiry of the previous National Drug Policy (which covered the period 2007 to 2012) provided an opportunity to re-think how we deal with these issues. The Ministry undertook public consultation and led cross-agency work to put a new policy in place. The new policy, released in August 2016, provides the overarching framework for the approach to alcohol and drug issues across government and represents a substantial change from the previous policy. In particular, it:

- widened the scope of the previous policy to include alcohol in addition to drugs
- made it clear that the key principle of the new policy is minimising harm; broadening the emphasis from primarily a law enforcement approach to include encouraging people to seek help, improving the availability of treatment options, and an emphasis on reducing alcohol-related harm
- included a wide range of specific actions to minimise harm, such as releasing a discussion document on the regulation of drug utensils, developing options for the offence and penalty regime for personal possession within the Misuse of Drugs Act, and reviewing the regulation of controlled drugs such as medicines for legitimate purposes.

The Ministry leads the Inter-Agency Committee on Drugs, which has oversight of the National Drug Policy 2015–2020. The committee’s annual report in June 2016 noted that good progress was made in the policy’s first year of implementation. In this regard, the Ministry has:

- developed a New Zealand position for the United Nations General Assembly Special Session on Drugs in 2016
- supported Associate Minister Dunne’s introduction of the Substance Addiction (Compulsory Assessment and Treatment) Bill to Parliament
- supported the Minister to obtain Cabinet agreement to publish a fetal alcohol spectrum disorder action plan
- provided support to the Minister to obtain Cabinet agreement to release a discussion document seeking feedback on appropriate regulation of drug utensils
- developed tier 1 statistics for alcohol harm (but not for other drug harm, because an appropriate national indicator of harm has yet to be identified).

Planned publication in 2015/16 of a literature review of population-level impacts of alcohol and other drugs and unmet needs has been deferred to 2016/17.

The Inter-Agency Committee on Drugs made recommendations to the Prime Minister on the annual allocation of money forfeited to the Crown under the Criminal Proceeds (Recovery) Act 2009. Information on which proposals are funded through this process is made public through the Government’s *Tackling Methamphetamine: An action plan* (Department of the Prime Minister and Cabinet 2010).

Review and re-contracting of methamphetamine treatment services

A review of the methamphetamine treatment services contracted by the Ministry concluded that there remains high demand for these services. Adult residential methamphetamine-related treatment services were re-contracted. Residential treatment services for young people were consolidated with one provider instead of three. Funding will be devolved to DHBs once the model of care for such services has been revised.

The health targets

The health targets are a set of national performance measures specifically designed to improve the performance of the health system. The Ministry and DHBs are collectively responsible for achieving the health targets. Meeting these targets makes a practical difference to individuals and families by improving access to services, reducing waiting times or preventing harmful conditions.

Table 1: Six health targets for 2015/16

Health target	Measures
Shorter stays in emergency departments	95% of patients will be admitted, discharged or transferred from an emergency department within 6 hours.
Improved access to elective surgery	The volume of elective surgery will be increased by an average of 4000 discharges per year.
Faster cancer treatment	85% of patients will receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks, by July 2016, increasing to 90% by June 2017.
Increased immunisation (also a Better Public Services action)	95% of 8-month-olds will have their primary course of immunisation (6 weeks, 3 months and 5 months immunisation events) on time, through to 30 June 2017.
Better help for smokers to quit	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. 90% of PHO*-enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking.
More heart and diabetes checks	90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years.

* PHO = primary health organisation.

Over the past year progress has continued towards meeting the government's health targets. Both the 'Improved access to elective surgery' and 'More heart and diabetes checks' health targets were met in each quarter of 2015/16. Quarter four results for the "Shorter stays in emergency departments", 'Increased immunisation' and 'Better help for smokers to quit' targets are two percent or less from their respective target goals. Results for the faster cancer treatment target have improved compared to 2014/15 however, further improvement will be required to meet target goal in 2016/17. The health target results for each quarter of 2015/16 are shown in Table 2.

Table 2: Health target results for DHBs, by quarters for 2015/16

Target area	Target 2015/16	Quarter 1 2015/16	Quarter 2 2015/16	Quarter 3 2015/16	Quarter 4 2015/16
Shorter stays in emergency departments Percentage of patients admitted, discharged or transferred from an emergency department within six hours	95%	92.4%	94.0%	94.0%	93.9%
Improved access to elective surgery Percentage progress against plan (discharges)	100%	103.9%	105.2%	105.8%	107.6%
Faster cancer treatment Percentage of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and need to be seen within 2 weeks	85%	69.2%	74.6%	75.0%	73.9%
Increased immunisation Percentage of 8-month-olds who have their primary course of immunisation at 6 weeks, 3 months and 5 months on time	95%	93.4%	93.7%	93.5%	92.8%
Better help for smokers to quit The percentage of:					
hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	95%	95.5%	95.5%	95.8%	96.1%
PHO enrolled patients who smoke and have been offered help to quit smoking by a health care practitioner in the last 15 months	90%	83.2%	85.0%	86.0%	88.1%
pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking	90%	93.6%	92.7%	94.4%	94.4%
More heart and diabetes checks Percentage of the eligible population who have had their cardiovascular risk assessed in the last 5 years	90%	89.8% ⁴	90.0%	90.3%	90.5%

The Ministry continues to measure and report on the health targets, and works closely with DHBs to achieve them.⁵ It has appointed a Ministry champion for each target, to work with the sector to ensure good practice and share innovations. The champion provides support, and is the key link between the Ministry and people working to achieve target results in the sector.

Quarter four of 2015/16 was the final quarter of the ‘More heart and diabetes checks’ health target. The result of 90.5 percent represents a notable increase from 46 percent when the target began in 2012. From quarter one 2016/17 a new health target focusing on childhood obesity will be introduced called ‘Raising healthy kids’. The target is ‘By December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions’.

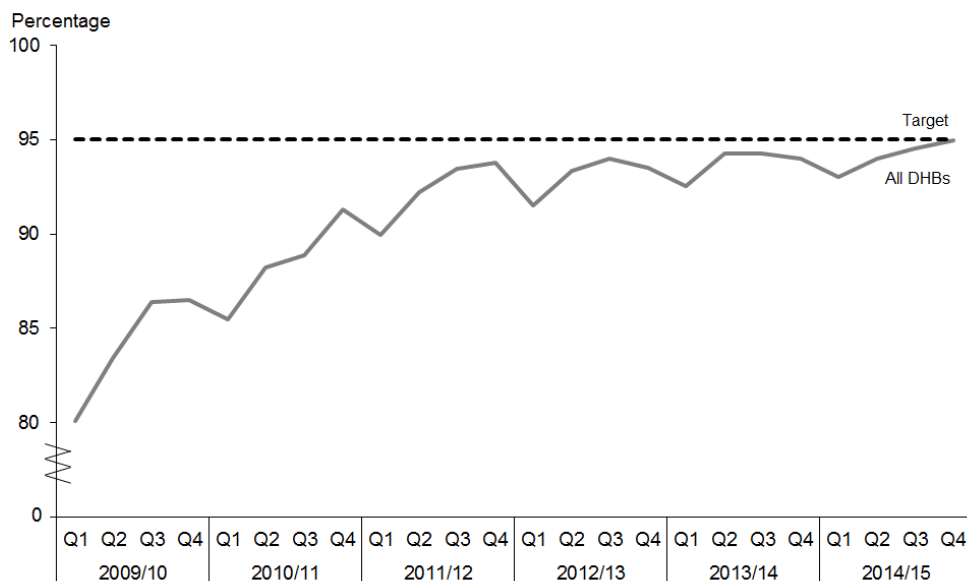
⁴ Officially published as 90% for quarter one of 2015/16.

⁵ Health target results are sourced from individual DHB reports, national collections systems and information provided by primary health organisations (PHOs). From quarter two 2015/16, PHO health target results are based on data sourced from the Ministry of Health and directly from PHOs rather than using information previously provided through Technical Advisory Services.

Shorter stays in emergency departments

The health target: 95 percent of patients will be admitted, discharged or transferred from the emergency department within six hours.

Figure 1: Percentage of patients admitted, discharged or transferred from an emergency department within six hours, 2009/10–2015/16



The length of time that a person spends in an emergency department is an important measure of the quality of acute (urgent) care in our public hospitals. The ‘Shorter stays in emergency departments’ health target measures how efficiently acute patients flow through our public hospitals. Longer stays in emergency departments are linked to negative clinical outcomes for patients, including increased risk of mortality and longer inpatient lengths of stay.

By the end of the fourth quarter of 2015/16, 93.9 percent of patients were being admitted, discharged or transferred from their emergency department within six hours.

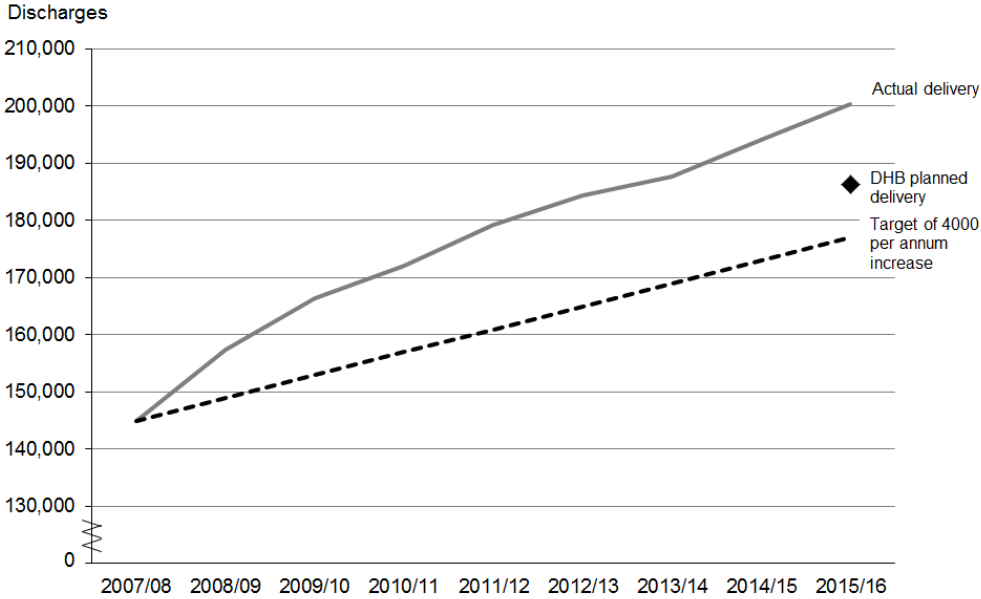
To support achievement of this health target, the Ministry has:

- hosted four winter planning workshops to support the health sector to improve their acute demand management over winter; the workshops were well attended by representatives from primary care, secondary care, ambulance services, Healthline and community pharmacy
- provided tailored one-on-one support to DHBs, including regular visits and teleconferences with DHBs that are not meeting the target.

Improved access to elective surgery

The health target: The volume of elective surgery⁶ will be increased by an average of 4000 discharges per year.

Figure 2: Volume of elective surgery, 2007/08–2015/16



The elective surgery target now includes elective and arranged in-patient surgical discharges, regardless of whether they are discharged from a surgical or non-surgical specialty (excluding maternity). In Figure 2, the target of 4000 per annum increase has been retrospectively applied to past years to acknowledge the revised target definition.

This target has consistently been exceeded, including in 2015/16. DHBs planned to deliver 186,223 elective surgical discharges and delivered 14,100 (7.6 percent) more than this. This represents an increase of more than 38 percent since 2007/08, or an average increase of more than 6900 elective discharges a year.

To support achievement of this health target the electives team engages with a wide range of clinical and management teams within DHBs and across professional bodies. The team clearly communicates its expectations, and works closely alongside sector teams to support progress and actively identify and resolve issues as they arise.

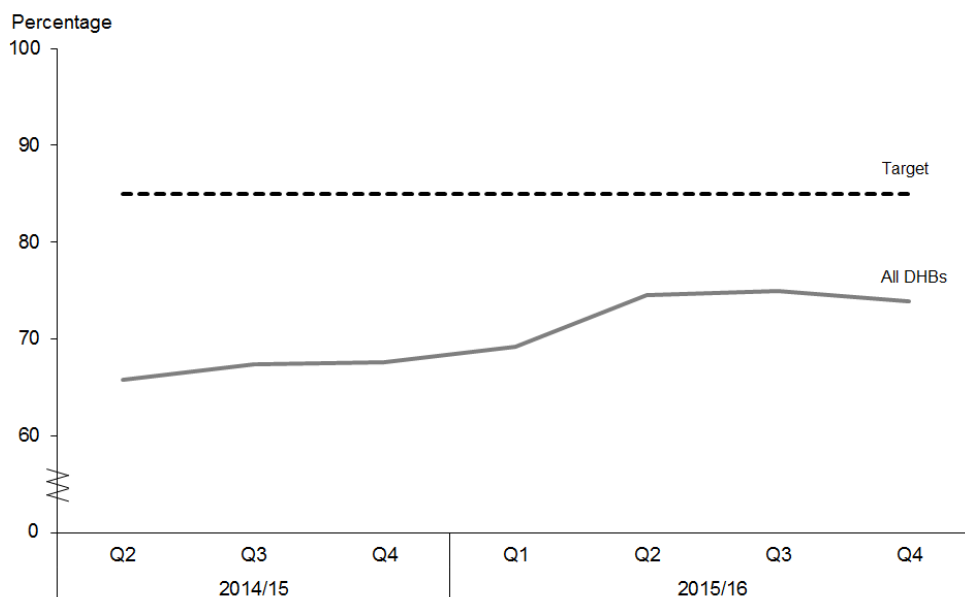
Joint elective services and faster cancer treatment health target meetings have been held with the DHBs’ clinical heads of surgery and anaesthesia in DHB regions.

⁶ ‘Elective surgery’ refers to planned rather than emergency procedures.

Faster cancer treatment

The health target: 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and need to be seen within two weeks by July 2016, increasing to 90 percent by June 2017.

Figure 3: Percentage of patients receiving their first cancer treatment within the target timeframe, quarter two 2014/15 to 2015/16



The target aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins. Prompt investigation, diagnosis and treatment is more likely to ensure better outcomes for cancer patients, and an assurance about the length of waiting time can reduce the stress on patients and families at a difficult time.

Since introduction, achievement of the 'Faster cancer treatment' health target has increased, with the 2015/16 quarter four result of 73.9 percent of patients received their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks. Results are based on six-months rolling data with quarter four results including patients who received their first cancer treatment between 1 January 2016 and 30 June 2016.

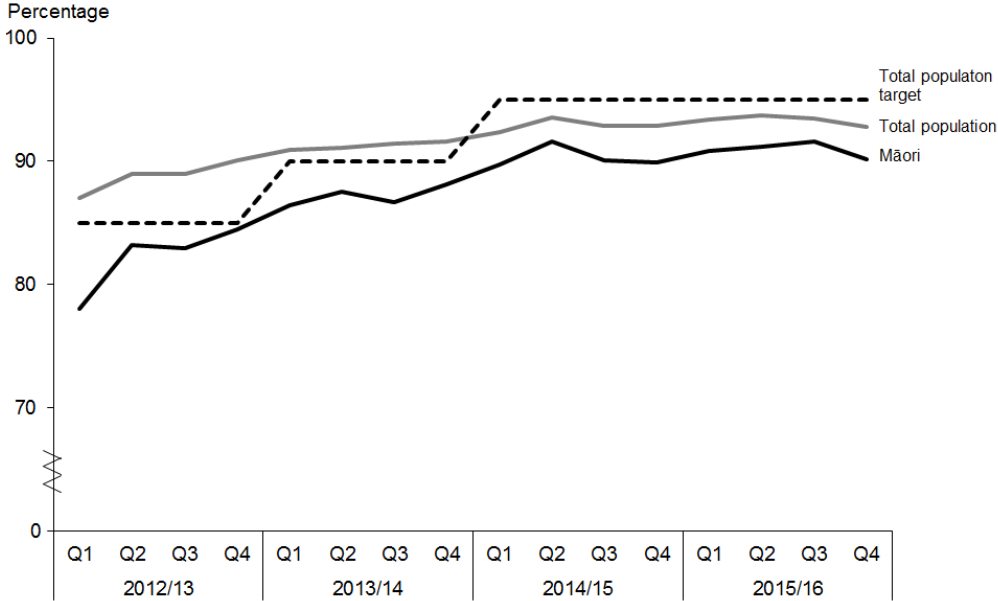
To support achievement of this health target, key initiatives include:

- regular national DHB teleconferences, individual DHB visits and regional cancer network meetings
- an \$11.2 million cancer service improvement fund to provide funding to DHBs and regional cancer networks to deliver time-limited initiatives that will improve cancer patient services
- an annual national Faster Cancer Treatment Forum to support DHBs and regional cancer networks to share their activities and learnings, review progress and identify key actions.

Increased immunisation

The health target: 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time. This coverage is to be maintained until 2017 as part of the Prime Minister’s Better Public Services results commitment.

Figure 4: Percentage of eight-month-olds fully immunised, 2012/13–2015/16



Immunisation not only provides individual protection for a number of vaccine-preventable diseases, but also provides population-wide protection by reducing the incidence of circulating infectious diseases and preventing their spread to vulnerable people. Some of these population-wide benefits only arise with high immunisation rates. Increasing coverage for eight-month-olds has required system level improvements in the whole immunisation system. Widespread immunisation reduces the impact of vaccine-preventable diseases on our health system.

Prior to introducing of the health target for immunisation at age eight months, coverage levels were at 86 percent overall and 78 percent for Māori. The difference in immunisation coverage between the total population and the Māori population is now only 2.6 percent. In 2015/16, coverage levels in each quarter ranged between 92.8 and 93.7 percent overall and between 91 and 92 percent for Māori.

Immunisation coverage for eight-month-olds was 92.8 percent in the fourth quarter of 2015/16, compared with the result of 92.9 percent for the same time period last year. Results for the eight-month milestone by ethnicity for the previous year were as follows: New Zealand European 93.3 percent, Māori 90.2 percent, Pacific 96.2 percent and Asian 97.7 percent.

Of the 14,965 eligible children aged eight months in quarter four, 13,890 were fully immunised. Timely immunisation of another 327 children was needed to meet the target. Some of these children will receive their vaccines by the time they are 12 months old. The delay may be due to sickness, travel, change of address or seasonal work. When coverage for the primary series of vaccines is measured at age 12 months rather than eight months, the coverage rate is 94.4 percent.

To support achievement of this health target, key initiatives have included:

- the Ministry’s health target champion and immunisation team working closely with DHBs and PHOs to increase immunisation coverage using a variety of mechanisms, including providing leadership, promoting immunisation, sharing best practice, reporting on coverage and sharing data to support identifying children overdue for immunisation
- a National Immunisation Workshop held in 2016 that identified strategies to strengthen immunisation as part of a wider wrap-around service to support vulnerable children and their families, to provide seamless service delivery and engagement from pregnancy through to late childhood, and to optimise synergies with other antenatal and child services
- development of new resources, including *Let’s talk about immunisation*, a discussion guide to help midwives, practice nurses and GPs talk to expectant parents about immunisation before babies are born, a key decision-making time for new parents.

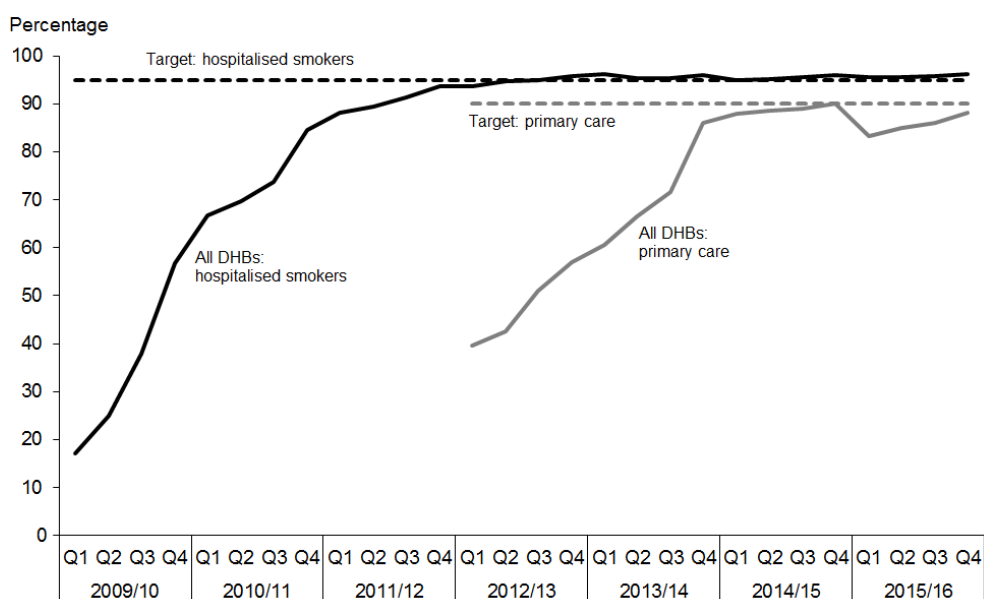
Better help for smokers to quit

The health target: 95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking. 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months. 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer are offered brief advice and support to quit smoking.

From quarter one 2015/16, the ‘Better help for smokers to quit’ primary care target has shifted to focus on the entire enrolled population of smokers, not just those seen in primary care, and now covers a 15-month period.

The hospital component of the target is no longer included in the newspaper publication from quarter one. The target results will continue to be published on the Ministry’s website along with the maternity tobacco target results (see www.health.govt.nz/healthtargets).

Figure 5: Percentage of smokers offered help to quit, 2009/10–2015/16



There is strong evidence that brief advice from clinicians is effective for prompting quit attempts and long-term quit success. The quit rate is further improved by the provision of effective cessation therapies, including pharmaceuticals and face-to-face support.

The quarter four 2015/16 result against the PHO target was 88.1 percent. This means that within the last 15 months 487,947 PHO-enrolled smokers were offered brief advice and/or support to quit smoking.

Performance on the hospital health target has increased steadily since results were first published in quarter one of 2012/13, when 40 percent of people were offered brief advice and support to quit smoking. The quarter four 2015/16 hospital target result is 96.1 percent, meaning that over 96 percent of hospital patients who smoke are now being offered help to quit.

The quarter four 2015/16 maternity target result is 94.4 percent of pregnant women, who identify as smokers upon registration with a DHB-employed midwife or lead maternity carer, were offered brief advice and support to quit smoking. Data comes from three sources: the Midwifery and Maternity Providers Organisation, lead maternity carer (LMC) services and DHB-employed midwives (if available). The maternity component of the health target continues to be treated as a developmental measure, and in the longer term existing data sources are expected to be replaced by the Maternity Clinical Information System, which is under development.

The Ministry has worked closely with the sector to support the achievement of the 'Better help for smokers to quit' health target. Examples of this work include:

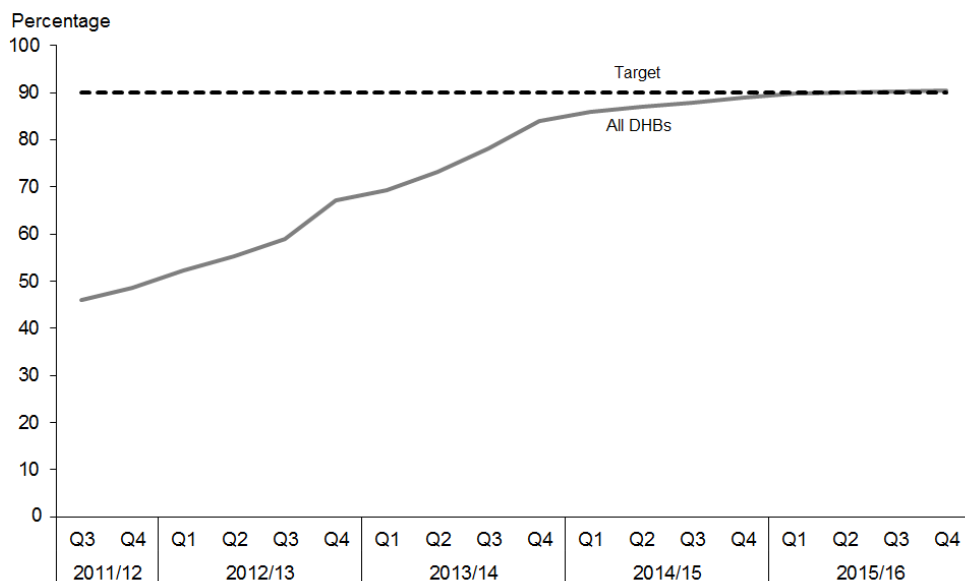
- supporting the poorer-performing DHBs and PHOs by regular teleconferences and sharing best practice strategies with the clinical teams
- PHOs increasing outreach activities to provide smoking cessation brief advice and support to smokers who do not visit their GPs.

Although the health target is supporting clinical practice change and driving positive results in the reduction of smoking rates, other initiatives in the wider tobacco control programme are also contributing to these outcomes.

More heart and diabetes checks

The health target: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.

Figure 6: Percentage of cardiovascular risk assessments completed, quarter three 2011/12–2015/16



Cardiovascular conditions are the leading cause of morbidity (disease) in New Zealand, and disproportionately affect Māori, Pacific and South Asian people.

This health target aims to increase the proportion of the eligible population who have had a cardiovascular disease risk assessment, including the tests to screen for diabetes, in the preceding five-year period. For those assessed at moderate or higher risk, the addition of lifestyle advice and treatment can substantially prevent the occurrence of heart attacks and strokes.

The ‘More heart and diabetes checks’ health target result for quarter four 2015/16 was 90.5 percent: an increase of 1.5 percent compared with the quarter four 2014/15 results of 89.0 percent. Performance on the health target has increased steadily since results were first published in quarter three 2011/12, when 46.0 percent of the eligible population had their cardiovascular risk assessed in the last five years.

To support achievement of this health target key initiatives have involved:

- planning for a Heart Foundation symposium in August to focus on maintaining risk assessment coverage and risk factor management
- a June roadshow to Auckland, Palmerston North and Christchurch focusing on the importance of early identification and potential changes to treatment thresholds.

Quarter four 2015/16 is the final quarter in which results for the ‘More heart and diabetes checks results’ will be reported as a health target. From quarter one 2016/17 this will become a DHB accountability measure. Quarterly monitoring and reporting will continue to help ensure the significant gains and performance improvements are embedded into DHB and PHO systems.

Implementing the Minister's strategic priorities

Making the best use of information technologies and ensuring the security of patient records

The Digital Health Work Programme will improve outcomes for New Zealanders through the smart use of digital health solutions. Initiatives include the establishment of a single electronic health record (EHR), which will collect and present health information into a single view accessible to a range of parties, including consumers and clinicians, and will provide decision support to clinicians.

The single electronic health record (HER) was announced by the Minister of Health in November 2015. It has the potential for data to be shared with social sector professionals to support health investments and the Government's social investment approach. Health information is increasingly being securely shared between government and non-government organisations to address complex social issues. The Ministry is the second largest contributor of data to the Integrated Data Infrastructure operated by Statistics New Zealand.

DHBs continue to implement regional IT systems, which are important sources of information for the single EHR. DHB systems have been benchmarked against an international methodology to assess and ultimately increase acute hospitals' digital maturity. This includes compliance with common standards needed to share information.

The Health Information Standards Organisation promotes the development and use of standards to ensure interoperability between systems. Systematised Nomenclature of Medicine clinical terms (SNOMED CT) has been endorsed as a national standard for clinical terminology in New Zealand.

The increasing levels of interoperability between health information systems supports services such as the electronic transfer of structured information. Primary care can transfer patient records securely between practices, send electronic referrals and receive electronic hospital discharge summaries. Pharmacists can electronically access prescriptions generated by general practices and other prescribers.

Following are some examples of work delivered over the past year.

- Electronic prescribing is in use in five hospitals to support the safe, effective and appropriate use of medicines through the eMedicines Programme, with plans for further roll-out in 2016/17.
- National Patient Flow has published phase 1 referral data on patients referred for specialist elective and cancer services, and phase 2 data collection is under way. National Patient Flow tracks the outcome of referrals and the time it takes for patients to access care.
- Health One, a system initiated at Canterbury DHB that brings together hospital, general practice, community pharmacy dispensing and care coordination patient data, is now in use in three of the five South Island DHBs.
- NGOs and primary care organisations have invested in a range of digital health solutions such as the Plunket eBook, St John's mobile ePatient record and patient portals.
- More than 330 practices have implemented patient portals and over 137,000 New Zealanders have registered to access their health information securely in real time.
- The South Island Patient Information Care System, a new regional hospital patient management system for South Island DHBs, went live at Canterbury DHB in June 2016.

- The real-time National Enrolment Service is being rolled out to primary care practices, providing a single source of all national enrolment and identity information, which will improve the experience for patients when interacting with their GPs. The GPs will have up-to-date patient information and will be able to validate the National Health Index, demographic information and eligibility for funding and services.
- The New Zealand Telehealth Forum is working with the Ministry to develop a national Video Conferencing Directory to support clinical uptake of telehealth. Telehealth will maximise the benefits of the Government's ultrafast broadband programme.
- Health information is being securely shared using the Connected Health environment, a standards-based commercial model for the delivery of universal connectivity across the New Zealand health sector, which is supported by ultrafast broadband.
- St John introduced an electronic patient report form to provide an integrated approach to delivering patient care. Having the technology at the point of care enables paramedics to gain information about the patient, capture their episode of care and send the completed form to the appropriate clinician.

Smarter use of information

There are many benefits to be gained from sharing and linking data held by multiple agencies, including the Ministry of Health. This data can be used for frontline and policy purposes and can enable better understanding and delivery of services to populations at risk of poor social outcomes.

In 2015/16, the government expanded the Integrated Data Infrastructure (IDI) to include more data from the social sector, which made this innovative mechanism available for the health sector to share information across agencies. The IDI enables government agencies and researchers to access de-identified, linked government-held data about individuals. The Ministry currently contributes data from 15 National Collections to the IDI. Valuable findings are emerging from IDI analysis, for example, client risk profiling and service mapping for the 0–5s and youth funding reviews.

The Ministry embarked on a multiyear research programme using the IDI in 2016. The research programme uses analysis of cross-agency linked data in the IDI to develop a better understanding of the wider costs and outcomes associated with health conditions and health service use (or non-use) that cannot be described using health data alone. The research programme will provide more information to other agencies and sectors about the relationship between people's health and social outcomes, and also provide more information about the health profiles of priority populations.

Making services more accessible, including more care closer to home

Closer to home is a key theme of the New Zealand Health Strategy. Central to this is:

- providing care closer to where people live, learn, work and play
- having integrated health services that make better connections with wider public services
- promoting wellness and preventing long-term conditions
- investing in health and wellbeing early in life.

Primary health care is the first point of contact for access to the health system. It is also the gateway to secondary health care and is integral to the success of the health system in terms of enabling care to be provided closer to home and managing health service costs.

In 2015/16 the Ministry undertook the following actions.

- The Ministry supported the implementation of changes that improved the pharmacy systems. The systems enable pharmacists to search a person's National Health Index (NHI) number, which allows pharmacists to confirm eligibility for a prescription subsidy card. This was implemented on 28 July 2015. It means that people no longer need to retain and produce prescription receipts to prove their eligibility.
- The Ministry implemented the integrated national telehealth service. Commencing in November 2015 the service brought together Ministry-funded health helplines: Healthline, Quitline, the Gambling Helpline, the Alcohol Drug Helpline, the Depression Helpline, and poisons and immunisation advice for the public. The consolidated service provides a robust technological and clinical foundation for better integration between helpline phone advice, triage, support and counselling, and referral to other health advice and face-to-face services, including emergency care.
- A system-level measurement framework was developed to provide the opportunity for an Integrated Performance and Incentive Framework to evolve into the system-level performance measurement envisioned in the New Zealand Health Strategy. The measurement framework is a combination of system-level measures that show progress, and contributory measures that stimulate and support quality improvement at a local level. Four system-level measures were being implemented from 1 July 2015, and two further measures will be developed over 2016/17 for implementation in 2017/18. These new measures require all parts of the health sector to work together to improve system-level performance.
- The Ministry completed the pilot stage of the primary care patient experience survey, which went live in February 2016. General practices will take up the survey during 2016/17 as they adopt the National Enrolment Service.
- The Ministry continued to support general practices to provide services to enrolled people, including under the very low cost access (VLCA) scheme. We also worked with the health sector to develop advice for the Minister on possible changes to the VLCA scheme and improvements to general practice effectiveness.

The Ministry also:

- supported projects with a particular focus on urgent and unplanned care, primary care management of patients with cardiovascular disease, diabetes, long-term conditions, wrap-around home care packages for older people, and seamless maternal and child health services
- monitored DHB performance against planned integration activities, including shifting services closer to home, integrated acute demand planning, and the development of clinical pathways – Counties Manukau, Canterbury and MidCentral DHBs continue to lead the way in this area
- continued to support the implementation of a National Child Health Information Platform (NCHIP) solution in the Midland region
- continued to work with DHBs to implement and increase the functionality of the Maternity Clinical Information System, which is in use in five DHBs.

Maintaining wellness by improving prevention

New Zealanders are living longer but are also more likely to spend a portion of their later years managing a long-term condition. It is important that we invest in ways to help people stay well for longer and prevent the onset of these conditions. This focus on maintaining wellness underpins a wide range of Ministry actions.

In 2015/16 the Ministry progressed programmes aimed at keeping people well, such as newborn screening, promoting good hygiene and working with other agencies on healthy housing.

Early prevention

Newborns are enrolled with general practices to ensure babies receive essential health care, including on-time immunisations. By April 2016, 77.4 percent of newborns were enrolled with general practice in the three-month period analysed. This was an increase from 57.4 percent in January 2013. The Ministry works closely across teams, and with both DHBs and PHOs, to ensure more newborns are being enrolled early.

Immunisation

The National Immunisation Programme protects against vaccine-preventable diseases across the lifespan. The actions include increasing immunisation rates in infants and children to protect against many diseases, including pertussis (whooping cough) and measles; increasing immunisation of girls against human papillomavirus; and protecting older and vulnerable people from influenza through high rates of vaccination.

Prostate cancer management

The *Prostate Cancer Management and Referral Guidance* was released by the Ministry in September 2015. One of the priorities of the awareness and quality improvement programme is for GPs and other health care professionals to be supported to provide men and their families and whānau with consistent information on prostate cancer testing and treatment options.

Guidance on using active surveillance to manage men with low-risk prostate cancer was published by the Ministry in June 2015. This guidance is for urologists and other health professionals involved in the management of men with localised, low-risk prostate cancer. It clarifies what active surveillance is and the roles and responsibilities of the different health professionals.

A Best Practice Advocacy Centre was commissioned to provide decision-making support to men and primary care health professionals to enable consistent, well-informed choices about prostate cancer testing and treatment. The decision support tool will be in line with, and will support the implementation of, the *Prostate Cancer Management and Referral Guidance*.

The Ministry is supporting the prostate cancer pathology roadshow in September 2016. The roadshow serves to enhance the professional development of pathologists through education on prostate cancer. The aim will be to improve the accuracy and consistency of prostate cancer diagnosis.

Service improvement programmes

The Long Term Conditions service improvement work programme included the launch by Ministers Joyce and Coleman of a partnership with the Health Research Council and the National Science Challenge. A two-stage application process was agreed to enable further work on promising proposals. A revised and updated self-management guidance document (Ministry of Health 2016c) was published on the Ministry website in February 2016. The Western Bay of Plenty PHO weight management project has been completed; the tools and resources will be made available on the Bay of Plenty DHB website.

Cardiac service improvement work included the development of accelerated chest pain pathways, quality improvement initiatives and ongoing support of the cardiac registries. All DHBs contribute to the cardiac registries, and this information is used to identify service improvement and support changes in clinical practice.

The stroke service improvement programme initiated the launch of the Face, Arm, Speech, Time (FAST) campaign in June 2016, jointly with the Health Promotion Agency and Stroke Foundation, to highlight the need to promptly access emergency services. A six-month Telestroke pilot commenced on 1 June 2016 to provide an acute thrombolysis service 24/7, improve patient outcomes, and reduce inequitable acute stroke service delivery. The pilot is hosted by specialists at Wellington Hospital supporting four smaller hospitals in the Central and South Island regions. Over the year DHBs have improved the average national percentages for the two stroke indicators.

The hepatitis C services programme supported DHBs to develop integrated hepatitis C assessment and treatment services through regional leadership and a service delivery focus on populations most at risk. Work was informed by a clinically led hepatitis C Implementation Advisory Group, who developed guidance covering the high-level hepatitis C clinical pathway, minimum requirements, quality assurance frameworks, minimum standards and data collection. Education and training activities were also developed to support the roll-out of funded hepatitis C treatments.

Health screening programmes

Population health screening programmes (via the National Screening Unit) are provided for breast and cervical screening, antenatal, newborn hearing and newborn metabolic disorders. The Ministry's national screening unit is responsible for delivering safe, effective and equitable screening programmes nationwide.

Following are some examples of the work progressed or delivered in 2015/16.

- A mortality evaluation of the national breast-screening programme was published. This major new study confirms that New Zealand's organised breast-screening programme, BreastScreen Aotearoa (BSA), is reducing deaths from breast cancer. The study concludes that for women who have been screened at least once by BSA, the rate of death from breast cancer is reduced by a third compared to women never screened by the programme. It also confirms that greater reductions in death rates are possible if participation targets are achieved in all priority groups and across the country. The findings of this study are in line with mortality studies of breast-screening programmes internationally.
- The Ministry engaged with the sector to develop a new service model to better target priority women in BSA and the National Cervical Screening Programme.⁷
- Policy and service development work was undertaken to support the change in 2018 from primary cytology screening to primary human papillomavirus (HPV) screening in the National Cervical Screening Programme.
- Undertaking a project to improve the timeliness, quality and completeness of colposcopy data received at the National Cervical Screening Programme register. The programme has been working closely with DHBs to support the implementation of the electronic reporting system in DHB colposcopy clinics. At 30 June 2016, 16 DHBs had gone live with electronic reporting of colposcopy data, with full implementation expected by the end of July 2016.

⁷ 'Priority women' in BreastScreen Aotearoa and the National Cervical Screening Programme are Māori and Pacific women, women who have never been screened, and women who are under-screened. In addition, Asian women are a priority group in the National Cervical Screening Programme.

- Completion of a new screening protocol and standardised screening equipment were introduced in all DHBs for the Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP). The UNHSEIP detects about 60 babies per year with moderate to severe or profound congenital hearing loss. (This programme is jointly overseen by the Ministries of Health and Education.)
- Work was undertaken to improve the timeliness of newborn metabolic screening, including measures to improve the transit time (the time taken for a blood spot sample to reach the laboratory after it has been taken). In order to reduce morbidity and mortality, timely detection of disorders is critical. The Newborn Metabolic Screening Programme screens babies for 24 rare but life-threatening metabolic disorders.
- Quality improvement initiatives were implemented for antenatal screening for Down syndrome and other conditions, with the aim of ensuring timely and accurate results are provided to pregnant women and their whānau. This included development of practitioner guidelines and feedback to radiology practices and practitioners on the quality of the measurements (nuchal translucency and crown rump length) taken during first trimester ultrasound scans.

Health literacy

A number of health literacy programmes have been introduced to support people to better understand health literacy and its impact. These include building whānau health literacy for a number of Māori who are enrolled for elective bariatric surgery and looking at a range of settings, including marae, where ongoing self-management can be built.

Bowel screening

Budget 2016 provides \$39.3 million over four years to begin implementation of the National Bowel Screening Programme. This will cover the cost of the design, planning and set-up phases. Additional funding has also been set aside for work on the national IT system and infrastructure needed for a national programme.

The roll-out of the national programme will see Hutt Valley and Wairarapa DHBs begin screening the eligible 60 to 74 years age group from mid-2017, with all other DHBs following in stages. Bowel screening will continue to be offered at Waitemata DHB, which will transition from a pilot to the national bowel screening model over the course of the roll-out. DHBs have worked hard to reduce waiting times for publicly funded colonoscopies and to improve the quality and efficiency of colonoscopy services.

While there are still challenges ahead, a national bowel screening programme will build on this progress and deliver improved bowel cancer detection to more New Zealanders.

Reducing obesity: Childhood Obesity Plan

Obesity is a risk indicator for a number of debilitating health conditions, particularly diabetes. Reducing obesity would be expected to enable people to live longer and better, as well as reducing the burden on the health system from obesity-related conditions. New Zealand rates of adult and child obesity are relatively high, and have been increasing.

In October 2015 the Government implemented the Childhood Obesity Plan. This is a package of 22 initiatives to prevent and manage obesity in children and young people. It includes targeted interventions for those who are obese, increased support for those at risk of becoming obese and

a broad base of population-based strategies to make healthier choices easier for all New Zealanders. (Examples of progress on some of the 22 initiatives are provided below.)

On 1 July 2016 the Ministry implemented a new 'Raising healthy kids' target to support this package of initiatives. This is one of two targeted interventions in the Childhood Obesity Plan that will reach at-risk young children and their families directly.

A practical resource, *Weight Management in 2–5 Year Olds*, has been developed by the Ministry to equip health providers with the most up-to-date advice to monitor, assess and manage children who are overweight and obese. It also includes sleep, nutrition and activity tips to assist caregivers of two- to five-year olds.

Eating and Activity Guidelines for New Zealand Adults

These evidence-based guidelines for use by health and physical activity practitioners were released in October 2015 as part of the Childhood Obesity Plan. The guidelines support New Zealanders to live well and stay well by reducing their risk of long-term conditions such as type 2 diabetes and obesity.

The new *Eating and Activity Guidelines* integrate advice on food, nutrition, healthy weight and physical activity into a single document for the first time. The core part of the publication is a series of statements or recommendations for healthy eating, maintaining a healthy weight, being physically active and minimising sedentary behaviour. Accompanying the guidelines are consumer resources, topical questions and answers, and related information, which are available on the Ministry's website.

National Healthy Food and Drink Policy

A sector network comprising DHBs and Ministry representatives has worked collaboratively to develop a consistent approach to the food environment within their organisations and demonstrate leadership in this important area. A three-stage process has been used to achieve this initiative in the Childhood Obesity Plan. The first stage was the removal of sugar-sweetened beverages from DHB facilities by 30 September 2015. The second stage was the development of healthy food and drink policy principles (aligned with the *Eating and Activity Guidelines for New Zealand Adults*) by 30 December 2015.

The third stage has been the development by the sector network of detailed nutrient criteria for use in hospital cafes, shops, vending machines and catering for staff and visitors. Key stakeholder consultation, including DHBs, health sector unions, food industry and catering companies, was undertaken. The National Healthy Food and Drink Policy is being considered for approval by DHBs and has been adopted by the Ministry. A generic organisational healthy food and drink policy has also been developed to support other agencies such as government departments, Crown agencies and local authorities to show leadership in the area of providing healthier food and drink environments for staff and visitors.

Implementing a diabetes plan

The Living Well with Diabetes Plan was launched by the Minister of Health in October 2015. The Plan provides a clear roadmap for how to tackle diabetes over 2015–2020. The objectives include reducing the burden of disease for people with diabetes by providing integrated services, and the tools and support people need to manage their health.

Services to support the Plan are under way, with two community-led weight management programmes running to June 2017 for people with or at risk of diabetes. Guidance papers and

advice were updated for pre-diabetes, retinal screening and self-management. The self-management guidance was developed after three workshops in 2015 to support people with long-term conditions, including diabetes. A consensus statement for chronic kidney disease was implemented, with a web-based decision support tool available for primary care.

Two DHB-led projects to support primary mental health for people with poorly controlled diabetes, along with a related evaluation, have been contracted. DHBs continue to implement and update the 20 quality standards for diabetes care. Regular monitoring of the DHBs' Diabetes Care Improvement Packages will continue through to June 2017. The Virtual Diabetes Register algorithm was reviewed and validated, and data was revised for the last five years.

Improving the quality and safety of health services

Publication of clinical performance and outcome information

The Office of the Chief Medical Officer is leading work, in collaboration with the Health Quality and Safety Commission (HQSC) and the Accident Compensation Corporation (ACC), towards publication of clinical information. The aim of publishing clinical information is to facilitate improvements in the quality and safety of health services for the benefit of consumers.

Consumers, employers, colleges and professional bodies will all be involved in developing the outcome measures. The Ministry, HQSC and ACC are in the process of finalising the principles that will underpin the ongoing work leading to publication of clinical information. The next step will include the development of nationally applicable standards to ensure consistency of approaches, such as data capture, definitions and measures.

Exploring the Link Report

In March 2016 government agencies, including the Ministry, The Treasury and HQSC, in collaboration with the Auckland, Bay of Plenty, Canterbury and Whanganui DHBs, collaborated to publish a report⁸ on the results of a project initiated in 2015. It provides an overview of each case study DHB and its approach to quality improvement, assesses the impact of quality improvement strategies on organisational outcomes, and offers useful lessons for organisations with an interest in quality and safety in the health sector.

A number of DHBs are using quality frameworks and concepts as core elements of their organisational strategies to improve patient outcomes and manage health care costs. The successes and challenges of these strategies can provide useful insights for other DHBs and the broader health system for evaluating existing programmes and developing new initiatives.

Supporting the health of older people

During 2015/16 the Ministry worked with older people and their families and whānau, DHBs, primary health care, service providers, NGOs and other government agencies to ensure health services are addressing the priority health needs of older people in consistent and integrated ways. Following are some of the achievements in 2015/16.

- The quality and safety of health services for older people were improved, with the number of four-year rest home certifications up from 89 in 2013/14 to 114 in 2014/15. Full rest home audit reports are now published online, giving people the information they need about how a rest home is performing. The audit framework for home and community support services is now fully implemented.

⁸ Published by The Treasury, Ministry of Health, Health Quality & Safety Commission New Zealand 2016.

- Implementation of the international Resident Assessment Instrument (interRAI) comprehensive clinical assessment framework in residential care for older people was completed, meaning that all older people who require either home care or residential care are assessed under an integrated, best practice assessment framework. This will result in more consistent and transparent care planning and, ultimately, well-targeted services that better meet the care needs of older people.
- A new interRAI NZ governance board and terms of reference were established.
- The implementation of the current dementia care position statement and dementia care pathways was supported. The Ministry has worked with DHBs, NGOs and the aged care sector to further develop dementia care pathways through regionally oriented services and implementing priorities identified in the dementia care position statement.
- The Ministry monitored DHB initiatives to encourage DHB geriatricians and gerontology nurse specialists to work with, advise and support health professionals in primary health care and aged residential care to improve the quality of care for older people. Some DHBs are using multidisciplinary community rehabilitation teams to help older people who are discharged from hospital. The Ministry monitors DHBs' progress through the DHB annual planning and reporting cycle.
- The Ministry continued collaboration with other government agencies to improve services for older people, including:
 - ACC and DHBs, to identify investment opportunities to reduce the impact on older people of fractures and falls
 - the Ministry of Social Development and other agencies, to develop more joined-up or integrated services to better meet the changing needs of New Zealand's ageing population, including a Department of Internal Affairs web portal providing access for older people to information on the government services available to them
 - the Office for Seniors, in its work to increase the number of age-friendly communities
 - the Ministry of Business Innovation and Employment, on regional growth initiatives involving trialling innovative supported housing initiatives for older people.
- The settlement in relation to home care workers' claim for time spent travelling between clients to be paid was implemented. The settlement, reached by DHBs, providers, unions and the Ministry, includes:
 - paying for travel time at the minimum wage from 1 July 2015 and paying standard mileage rates from 1 March 2016
 - reviewing the home and community support sector
 - a move towards a regulated accreditation process for the home and community support workforce
 - establishing and implementing systems to provide in-between travel payments and enacting legislation to prevent future similar claims.
- The Ministry monitored the implementation of the additional charging framework in residential care. This framework was introduced in 2014 to enable residential care providers to charge higher prices for higher-quality facilities, while ensuring that beds would continue to be available at standard prices for those who could not pay additional charges.
- The Health of Older People Strategy is being refreshed in response to the Government's request for the Ministry to develop an updated New Zealand Health Strategy. The refreshed Health of Older People Strategy will provide a road map for future improvements to health services for older people over the next 10 to 15 years. A draft refreshed strategy was forwarded to Cabinet for consideration at the end of 2015/16. The draft followed a period of significant engagement with the health and social sectors and older people and their families on what the priorities are for a refreshed strategy. Over 40 workshops were held around the

country and more than 2000 people actively participated. Public consultation will occur from July to September 2016, after which the strategy will be finalised and approved by Cabinet. An implementation plan will be developed to guide the new strategy's implementation in the coming years.

- The Ministry funded the production of Māori child health research reports, *Life and Living in Advanced Age Cohort Study (LiLACS) NZ*, a longitudinal cohort study of New Zealanders aged 80 years and above living in the Bay of Plenty and Rotorua. There is a lack of good information about the health and wellbeing of people in advanced age, and the Ministry has commissioned these reports to inform health service planners and providers in the aged care sector on how older Māori and non-Māori compare in terms of health status and access to health care (Kerse and LiLACS NZ 2015a, 2015b, 2015c, 2015d).

Implementing Rising to the Challenge

The Ministry continues to monitor progress on the implementation of Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017. The Plan sets the direction for mental health and addiction service delivery across the health and disability system over a five-year period. It outlines key priority actions for achieving further sector-wide changes to make service provision more consistent and to improve outcomes for both the people who use services and their families and whānau. Rising to the Challenge focuses on four overarching goals:

- making better use of resources
- improving integration between primary and secondary services
- cementing and building on gains for people with high needs
- delivering increased access for all age groups, with a focus on infants, children and youth, older people, and adults with common disorders such as anxiety and depression.

Examples of key initiatives under the Plan include:

- the Prime Minister's Youth Mental Health Project
- the full implementation of the adolescent e-therapy tool SPARX⁹
- the New Zealand Suicide Prevention Action Plan 2013–2016
- acute perinatal and infant mental health services being delivered in the North Island
- two alcohol and other drug treatment courts (in Auckland and Waitakere)
- treatment programmes for repeat impaired (drink) drivers
- providing 40 new full-time equivalents (FTEs) in regional Youth Forensic Community Services, taking the total number of FTEs to 74
- shifting appropriate secondary mental health and addiction services closer to home by providing more community services as alternatives to inpatient specialist beds
- substantial investment each year in primary mental health services to improve access to talking therapies and other psychosocial responses.

⁹ SPARX is an online game-style tool to help young people develop skills to deal with feeling down, depressed, anxious or stressed. It was developed by a team of researchers from the University of Auckland and has been made available, free, online through the Prime Minister's Youth Mental Health Project. SPARX is available at www.sparx.org.nz As well as the SPARX e-therapy programme, the website also offers a mood quiz to help young people identify depression and information on where to get help.

Suicide prevention

All DHBs have suicide prevention plans in place to guide their responsibilities for facilitating cross-agency collaboration in local suicide prevention. Early observation is that this has resulted in a stronger and more coordinated response to significant events in communities.

Opportunities for new and strengthened approaches to inform efforts to prevent suicide include:

- the implementation of the Suicide Prevention Outcomes Framework
- the refreshed New Zealand Suicide Prevention Strategy and Action Plan
- the Office of the Auditor General's audit of the collection and use of information on suicide
- the potential of the Suicide Mortality Review Committee to add momentum and a central focus to analysis of the issues and identification of effective intervention points.

The refresh of the current Strategy and the Action Plan has commenced.

Gambling harm minimisation

The Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19 has been completed and published following a comprehensive consultation and agreement process.

Cross-agency project on conduct problems

In August 2015 the Social Sector Board (Deputy Chief Executives) agreed to provide governance to the cross-agency project conduct problems and signed off on the project plan. There is strong agency support for the project, as reflected in the participating agencies all dedicating resources to it. Following the release of the expert panel's final report, *Investing in New Zealand's Children and their Families*, the Deputy Chief Executives signalled that governance for the project should shift to the Vulnerable Children's Board because the project is a key enabler for the work of this new children's entity.

The project is on temporary hold while the infrastructure and resources to progress the service design work are established for the Vulnerable Children's Board and high-level decisions are made on how best the Ministry can contribute. The project aims to develop a model for a service system and an investment proposal to address service gaps for consideration through the Social Sector Investment Change Programme.

Rural Mental Health Initiative

In June 2015 the Ministers of Health and Primary Industries jointly announced a one-off funding allocation of \$500,000 for rural mental health initiatives as part of an emergency response to financial and environmental factors affecting rural communities.

The funding enabled the Rural Health Alliance Aotearoa New Zealand to deliver 42 suicide prevention workshops to rural health professionals, social workers, school counsellors, Māori health providers and others. The Alliance also appointed 15 clinical champions and a medical director to strengthen links between health professionals and Rural Support Trusts.

In June 2016 the Ministers of Health and Primary Industries committed to invest a further \$600,000 to further strengthen rural mental health networks, provide more workshops and develop a longer-term strategic approach to rural mental health and addiction outcomes.

Smokefree Aotearoa New Zealand 2025

Tobacco use is a leading modifiable health risk factor in New Zealand, accounting for around 5000 deaths a year. New Zealand has a comprehensive tobacco control programme that incorporates internationally recommended strategies for legislation, taxation, health promotion and smoking cessation services to minimise the harm from tobacco. The Government has set an aspirational goal of reducing smoking prevalence and tobacco availability to minimal levels to make New Zealand essentially a smokefree nation by 2025.

The smoking rate is steadily decreasing but remains high in some groups, particularly Māori. The rate of daily smoking has decreased from 18.3 percent in 2006/07 to 15 percent in 2014/15. The total amount of tobacco consumed per capita fell by nearly 23 percent from 2010 to 2014, and, importantly, the rate of daily smoking by Year 10 students (14 and 15 years of age) has decreased from over 15 percent in 2000 to under 3 percent in 2014.

Key areas of focus for the tobacco control programme over the past year have included: securing annual excise tax increases for tobacco products of 10 percent until 2020; the progression of the plain packaging amendment bill; increasing taxation on tobacco products; consultation on the draft standardised packaging regulations; consultation on the regulation of electronic cigarettes; and advice on the illicit trade protocol.

Smokefree New Zealand 2025 Innovation Fund

The Smokefree New Zealand 2025 Innovation Fund was established to invest in the design, development, promotion and delivery of innovative efforts to reduce the harm and wider costs of smoking through a supportive and comprehensive public health environment approach. Two rounds of funding were distributed and over 24 programmes were funded. Most programmes ended in June 2016, and the remaining programmes will finish by the end of 2016. All programmes will be evaluated and a summary of evaluations will be available on the Ministry website.

Therapeutic products regulatory regime

Cabinet was advised and has made decisions on the strategic direction for the therapeutic products regulatory regime, the main elements of its design and a number of related matters (such as the prescribing framework). These high-level decisions will now guide the work on the detailed design of the scheme and how it is set out in legislation, regulations, and regulator-made instruments.

There has been considerable engagement with the therapeutic products industry (medicines, medical devices, and cell and tissue therapeutic products), health professional representative groups, the pharmacy sector and other interested parties, which will continue and deepen. The Parliamentary Counsel Office and the Legislation Design Advisory Committee are working on the design and content of the Therapeutic Products Bill.

Strengthening the health and disability workforce

The Ministry is committed to building a sustainable, flexible and fit-for-purpose workforce in a dynamic environment. The Ministry continues to drive the workforce response to shifting patterns of illness and disease, and the increasing focus on prevention, self-care, home-based care and community care. This includes initiatives aimed at developing a workforce that is capable, appropriately trained, motivated, supported and flexible enough to deliver on health targets and government and wider Ministry priorities for health.

In 2015/16 the Ministry funded the following health and disability workforce initiatives.

- The Voluntary Bonding Scheme provides incentives for new graduates to work in hard-to-staff professions and/or specialties and hard-to-staff communities. In the 2016 calendar year there were 333 new registrants: doctors, GP trainees, nurses, midwives, medical physicists, radiation therapists and sonographers were on the scheme, with dentists included for the first time.
- The Nursing Entry to Practice (NETP) programme enables new graduate nurses to practise in well-supported and safe environments and to build a sustainable pathway for the nursing workforce into the future. In the 2015 calendar year funding was provided for 1178 NETP placements, 42 NETP placements in aged residential care and 175 Nurse Entry to Specialist Practice placements.
- The Midwifery First Year of Practice Programme provides a mix of mentoring and education to support new midwifery graduates in their first year in the workplace. The compulsory programme has three cohorts per year and will see 161 new midwifery graduates completing in the 2016 calendar year.
- The Midwifery Recruitment and Retention service provides support to rural midwives to ensure there are sufficient midwives to meet demand for maternity services in rural areas. In the 2015 calendar year 478 locum placements and 10 rural relocation grants were provided to support rural midwives.
- Health Workforce New Zealand (HWNZ) continues to fund the Royal New Zealand College of General Practitioners for the training and employment of GP registrars as part of the General Practice Education Programme (GPEP). In the 2016 calendar year 182 registrars enrolled in GPEP1, compared to 169 in 2015.
- The Pharmaceutical Society of New Zealand, on behalf of HWNZ, completed the successful introduction of pharmacy accuracy checking technicians into the pharmacy workforce. These technicians carry out the final check on a dispensed item, a task previously undertaken by a pharmacist. Introduction of this role has resulted in increasing the time pharmacists spend on patient-focused activities without compromising public safety in the dispensing of medicines.

Following are some of the additional initiatives undertaken in the 2015/16 financial year to support building a sustainable workforce.

- HWNZ continues to work with the Medical Colleges to bring together medical specialty factsheets to support graduate doctors to make appropriate career choices and to have opportunities for employment in New Zealand. Fifty factsheets are now on the [Kiwihealthjobs](http://kiwihealthjobs.govt.nz) website, and these are updated as new information becomes available.
- HWNZ, in conjunction with key stakeholders, has over-arching responsibility for the coordination of community-based clinical attachments (CBAs), including urgent care, hospice, community mental health and other community-based services, and in general practice. Completing a 13-week CBA helps trainees to understand the interface between primary and secondary care and prepare them for future practice. As at June 2016, 19 percent of interns had completed a CBA.
- HWNZ has strengthened its data intelligence of the regulated health workforce by developing a forecasting model that projects the age and size of a workforce in 10 years' time. The model has been used to estimate the future supply of New Zealand's medical and nursing workforce and the allied health workforce. The workforce projections in the model have enhanced HWNZ's work with stakeholders in identifying how they can support a sustainable health workforce that is able to meet future demand for health care.

- Following engagement with key stakeholders, both within and outside the medical workforce, HWNZ and the DHBs are co-developing an alternative funding model for medical vocational training that can be progressively implemented over a three- to five-year period. Implementation of such a model is expected to ensure workforce sustainability and sector capacity and capability to address future health needs.

Ministry of Health Pacific scholarships

In 2015/16 the Ministry funded 164 Pacific students through the ANIVA scholarships. Scholarships are awarded to Pacific students pursuing a career in health or a health-related subject. As at the end of the 2015 academic year the ANIVA programme had developed and received New Zealand Qualifications Authority approval and accreditation of Pacific specialty qualifications, in partnership with Whitireia Community Polytechnic, as follows.

- The postgraduate Diploma in Specialty Care (Pacific Health), which builds on the established Postgraduate Certificate in Specialty Care (Pacific Health), was offered in 2015 for the first time. Twenty-four students were enrolled in this programme, and 22 students (92 percent) completed the qualification. Ninety-five percent of students said their expectations for the programme were exceeded or met.
- Level 4 of the National Certificate in Mental Health and Addiction Support (Pacific Health) (the ‘unregulated programme’) attracted enrolment of 40 students, of whom 82.5 percent completed their qualifications. All the students said that their expectations for the programme, which was offered for the first time in 2015, were exceeded or met.
- The Master of Professional Practice (Pacific Leadership), which completes the development of a Pacific Specialty academic and career pathway for Pacific nurses, was delivered for the first time in 2016.
- Of the 24 students enrolled in the existing Postgraduate Certificate in Specialty Care (Pacific Health), 88 percent completed their qualification; nine percent of students said their expectations for the programme were exceeded or met.

Pacific Health Science Academy and mentoring

Three Pacific Health Science Academies (PHSAs) were established in low-decile schools in Auckland as part of Programme Working and Achieving Together (Programme W&AT!). Programme W&AT! is managed by the Pacific Health Unit at Counties Manukau Health within the Counties Manukau DHB. In addition to the Health Science Academies, Programme W&AT! also delivers a Pacific Tertiary Student Programme. By the end of 2015 over 70 students from years 11 to 13 had been offered a place at the PHSAs.

Pacific orientation programme at University of Otago

There was an increase in the number of Pacific students who successfully gained entry into the health professional and/or allied health programmes at the University of Otago. In 2015, 34 students were offered a place within one of the programmes. Five years ago, prior to starting this enhanced learning programme, there was an average of five Pacific students per year enrolled in a health professional course.

Supporting regional and national collaboration

National service planning

During 2015/16 the Ministry continued to develop and support designated national services. The Ministry:

- worked with Clinical Genetics to improve access to first specialist assessment
- progressed establishing a National Intestinal Failure Service, with a focus on supporting clinicians in regional hospitals to identify and appropriately manage patients to improve outcomes; a clinical governance board has been established to oversee the progress
- progressed the establishment of the national renal transplant service, which aims to lift live donor kidney transplants by 10 per year; a national strategic leadership team has been established to oversee progress within the service
- reviewed hyperbaric services to develop a sustainable service model
- supported developing service models for perinatal pathology, epilepsy and vascular services.

Other Ministry priorities

Māori health research

Baseline information on older peoples is presented in the Life and Living in Advanced Age Cohort Study (LiLACS) NZ, a longitudinal cohort study by the University of Auckland of Māori and non-Māori aged 80 years and above living in the Bay of Plenty and Rotorua. There is a lack of good information about the health and wellbeing of people in advanced age and the Ministry has commissioned these reports to inform health service planners and providers in the aged care sector.

The Ministry funded research and monitoring reports on:

- Māori child health and young people with chronic conditions and disabilities (Craig et al 2014) as well as health determinants (Simpson et al 2015): these publications are used by those working in the health sector to improve health outcomes for Māori children and young people, and provide a relevant evidence base to assist the Ministry and DHBs to develop programmes and interventions focused on addressing the health needs of Māori children and young people
- DHB Māori health profiles: statistical data to inform good planning to improve Māori health outcomes was released in October, and this set of publications presents a snapshot of Māori health compared with non-Māori health across a range of health and disability related indicators.

Pacific Innovation Fund

As part of the Government's 2012 Budget, the Ministry established the Pacific Innovation Fund. The purpose of the Fund is to invest in Pacific health initiatives that will demonstrate innovation through the application of new strategies, models and methods of service delivery.

The Ministry funded seven contracts to deliver Pacific-specific innovation projects. The projects cover a range of health aspects for Pacific people, such as obesity, antenatal care and suicide prevention. For all contracts an evaluation has been completed or a plan is in place to have an evaluation completed. The evaluations received suggest that the innovation projects have been delivered in a way that engages with and meet the needs of the Pacific communities they serve.

Maternal and child health

Changes have been made to improve the access to and delivery of maternity and child health services. Further work is being progressed under a wider programme of work relating to the Ministry's contribution to the Investing in Children and Enhanced Access to Universal Services work programmes. The Ministry is also developing a longer-term work programme to improve service access and outcomes for pregnant women, children, families and whānau.

Child and Family Maternity Quality Initiative

The Child and Family Maternity Quality Initiative is the Ministry's programme for improving quality and safety in the maternity sector. The first workstream has focused on projects that promote and strengthen maternity services (eg, establishing the Maternal Fetal Medicine Governance Board). The second workstream has focused on projects that support the women and families who most need high-quality, comprehensive, integrated care (eg, smoking cessation, alcohol and other drugs in pregnancy, and improved maternal mental health services).

The third workstream has seen maternity quality and safety programmes embedded in DHBs, as well as implementation of the *Gestational Diabetes Management Guideline*, the convening of MATCON 2015 (a national maternity conference) and the ongoing work of the National Maternity Monitoring Group. Projects in the final workstream have increased maternity service integration, as evidenced by the alliancing contract with the NZ College of Midwives, and the ongoing implementation of the Maternity Clinical Information System in the five early adopter DHBs.

Palliative care and hospices

Budget 2015 invested \$76.1 million over four years to support hospice sustainability and fund new and innovative services in aged residential care, primary care and community settings.

- Fifty-two million dollars over four years was disbursed to DHBs from 1 July 2015 to support the sustainable funding of hospices, including funding some current services.
- By the end of 2015/16 new services totalling \$13.4 million over four years and involving 15 DHBs and 22 hospices had also been agreed. Funding for the remaining five DHBs is being considered as hospices finalise new service proposals.
- Approximately 40 FTE clinical positions have been established, with another 20 likely when the remaining service proposals are finalised. These positions will provide specialist advice, education and support to aged residential care services, primary health and community services staff, to ensure the provision of high-quality palliative care.

Oral health

Community oral health services

Over the past eight years the Ministry and DHBs have implemented a major re-investment programme in child and adolescent health. The reinvestment programme is showing encouraging improvement in child oral health outcomes, as well as community oral health services enrolment and attendance.

Between 2007 and 2014 (the latest available data):

- the percentage of children who were caries-free at age five increased from 51 percent to 59 percent (the results for Māori five-year-olds increased from 29 percent to 40 percent caries-free, and for Pacific five-year-olds from 29 percent to 35 percent caries-free)

- the average number of decayed, missing and filled teeth (DMFT) per five-year-old child reduced (ie, improved) from 2.27 to 1.83 (the results for Māori five-year-olds reduced from 3.67 to 2.96 average DMFT, and for Pacific five-year-olds from 3.85 to 3.29 average DMFT).

At December 2015, 247,849 preschool children were enrolled with community oral health services, equating to 81 percent of the eligible population. The preschool enrolment rate has been steadily increasing since 2007, when it was 43 percent.

Electronic oral health record

The electronic oral health care programme is a priority project for the Oral Health team. When implemented, the electronic oral health record will contribute the oral health component of the comprehensive electronic medical record for each patient. It is anticipated that improved capture, quality and access to oral health data will support clinical decision-making, provide operational efficiencies, improve patient experience and provide more robust and timely data for service development and planning.

To provide strategic direction, the Ministry has established a programme board, which met for the first time in November 2015. It has also put in place a team to deliver the programme, which has been working closely with all DHBs and other stakeholders to understand their current situation and requirements in order to codesign the approach for achieving a national electronic oral health record.

Oral Health Promotion Initiative

A Government investment of \$10 million over four years has been made for an oral health promotion initiative to promote preschool oral health. Preschoolers from Māori, Pacific and low-income families/whānau are the priority groups due to their significantly poorer oral health outcomes from childhood to adulthood. The initiative includes the development of a national social marketing campaign and the distribution of toothbrushes and toothpaste to families/whānau and their young children.

In 2015 the Ministry contracted the Health Promotion Agency to undertake formative development work on child oral health to help inform the initiative. Three pieces of work were carried out: a literature review on oral health in children under five years; consumer research with parents, caregivers and whānau; and stakeholder engagement along with a resource stocktake.

In March 2016 the Ministry commissioned the Health Promotion Agency to develop and deliver a national social marketing campaign, based on the formative development work already conducted, to improve preschool oral health for children aged under five years. This phase of the campaign is expected to go live in 2016/17.

Decision-making on the fluoridation of drinking-water supplies

In March 2016 Cabinet agreed proposed legislative changes to enable DHBs, rather than local authorities, to decide which community water supplies are to be fluoridated in their areas.

The Ministry is working to develop the Bill for introduction to the House. This includes developing the legislation for introduction to the House; developing operational policy for DHBs; and addressing other implementation issues. The Ministry will be seeking input from DHBs and local government to help inform the work.

Achieving our objectives

Overview of the Ministry's outcomes framework

The Ministry's 2015/16 outcomes framework contains two outcomes for the health and disability system.

- New Zealanders live longer, healthier, more independent lives.
- The health system is cost-effective and supports a productive economy.

These health and disability system outcomes support the achievement of wider government priorities.

The Ministry itself had three high-level outcomes that supported the achievement of the health and disability system outcomes above.

- New Zealanders are healthier and more independent.
- High-quality health and disability services are delivered in a timely and accessible manner.
- The future sustainability of the health and disability system is assured.

Many factors influence outcomes. In helping to achieve these outcomes, the Ministry will have a real impact on the lives of New Zealanders. The health and disability system is dynamic and integrated, and many of our activities contribute to a number of our long-term outcomes and impacts.

The Ministry's work is directly aimed at achieving seven impacts, which contribute to our higher-level outcomes.

1. The public is supported to make informed decisions about their own health and independence.
2. Health and disability services are closely integrated with other social services, and health hazards are minimised.
3. The public can access quality services that meet their needs in a timely manner, where they need them.
4. Personalised and integrated support services are provided for people who need them.
5. Health services are clinically integrated and better coordinated.
6. The health and disability system is supported by suitable infrastructure, workforce and regulatory settings.
7. Quality, efficiency and value for money improvements are enhanced.

The Ministry's outcomes framework (including the impact measures) will be reviewed now that the update of the New Zealand Health Strategy has been completed.

A well-functioning health system contributes to improved health outcomes for the New Zealand population as a whole, and for particular groups such as Māori, Pacific peoples, older people and vulnerable children.

Health and disability system outcomes

New Zealanders live longer, healthier, more independent lives

Health expectancy improves over time

Health expectancy (or independent life expectancy) is the number of years a person can expect to live in good health and without an impairment needing assistance.¹⁰ In 2006 health expectancy for males was 67.4 years and health expectancy for females was 69.2 years. This reflects an improvement of 2.7 years for males and 1.7 years for females since 1996, and the Ministry expects to see further improvements.

Health expectancy shows the length of life that a person born today can expect to live in full health if current patterns of illness, disability and mortality continue. In New Zealand we can measure health expectancy in two ways; independent life expectancy and health-adjusted life expectancy.

Independent life expectancy (ILE) is a measure of the number of years a person can expect to live free of disability requiring daily assistance. Based on the 2013 post-censal Disability Survey, independent life expectancy for individuals born in 2013 was estimated as 65.2 years for males and 66.5 years for females. This compares to 63.8 years for males and 66.4 years for females in 1996.¹¹

Health-adjusted life expectancy (HALE) is a summary measure of the years a person can expect to live in full health. Based on the 2013 Global Burden of Disease estimates, a New Zealand male born in 2013 can expect to live 68.2 years in full health (86.8 percent of his life), while a female can expect to live 70.5 years in full health (85.2 percent of her life). Between 1990 and 2013 HALE at birth increased by 4.9 years for males and 3.3 years for females.

Both measures show that health expectancy at birth is increasing. However, health expectancy is not increasing at the same rate as life expectancy. From 1990 to 2013 the difference between life expectancy and health expectancy (HALE) increased from 9.2 to 10.4 years for males, and from 11.0 to 12.2 years for females (Ministry of Health 2016a). Hence while New Zealanders are living longer in good health, they are also living longer in poor health.

How do we compare with other countries?

In 2013, when compared to Australia, Canada, the United States, the United Kingdom and Ireland, New Zealand HALE was similar in the mean for these six countries: 70.5 vs 70.3 years for females and 68.2 vs 68.0 years for males.

Life expectancy increases over time

Life expectancy at birth indicates the number of years a person can expect to live, based on the mortality rates of the population at each age in a given year or period. In the period 2007–2009 life expectancy at birth was 78.4 years for males and 82.4 years for females. Between the periods 1985 and 1987 and 2007 and 2009, life expectancy at birth increased by 7.3 years for males and 5.3 years for females. The Ministry expects to see further improvements over time.

¹⁰ 'Full health' is defined here as 1 minus the all-cause YLD (years lost due to disability) rate.

¹¹ The 2013 results are not comparable with 2006 ILE measures due to differences in the questions used in the 2006 and 2013 post-censal Disability Surveys (Ministry of Health 2013), so the comparison is against 1996 data.

Life expectancy is a summary measure of mortality. Life expectancy at birth is the number of years a person born today can expect to live, given the current age-specific mortality patterns. Overall, New Zealanders are living longer than ever before. In 2014 life expectancy at birth was 79.8 years for males and 83.3 years for females. Recent improvements in life expectancy are mainly due to lower mortality rates in the older age groups. The gap between male and female life expectancy at birth has narrowed over time.

Improvements in Māori life expectancy at birth since 1995/97 have narrowed the gap between Māori and non-Māori. With a life expectancy at birth of 73.0 years for males and 77.1 years for females during 2012–2014, Māori life expectancy at birth remained, respectively, 7.3 years and 6.8 years lower than that for non-Māori.

Pacific life expectancy at birth has also increased over the past years. In the 2012–2014 period life expectancy at birth for the Pacific population was 74.5 years for males and 78.7 years for females. For both sexes this is up 1.3 years since 2005/07, but, respectively, 5.0 years and 4.5 years lower compared with the total New Zealand population.¹²

How do we compare with other countries?

New Zealand compares well with similar countries for life expectancy. For males, life expectancy at birth was 1.9 years above the Organisation for Economic Cooperation and Development (OECD) average in 2014 (77.9 years); for females it was 0.1 years above the OECD average (83.3 years). In 2014 the average New Zealand life expectancy of 81.6 was 1.0 years above the OECD average of 80.6.¹³

The health system is cost-effective and supports a productive economy

Life expectancy by health spending per capita compares well within the OECD

New Zealand has maintained its position within the OECD as having relatively high life expectancy for relatively modest expenditure. New Zealand performs well internationally with respect to life expectancy in terms of health spending per capita: it has relatively high life expectancy for comparatively modest health expenditure.

In 2013 New Zealand achieved higher life expectancy than could be expected (the 14th highest among 34 countries) given expenditure on health care (18th highest among 34 countries) relative to other OECD countries.¹⁴

Health spending growth slows over time

The projected rate of growth in health spending between 2010 and 2019 should be less than the rate of growth between 2000 and 2009 (25.8 percent based on real per capita expenditure in 2011 dollars).

Vote Health is a significant component of government expenditure. The Minister is responsible for appropriations in the Vote for the financial year. The Ministry has a duty to ensure the wider health and disability system is managed in an efficient and productive manner while ensuring

¹² NZ Social Indicators: Life Expectancy, 2014. URL: www.stats.govt.nz

¹³ OECD Health Statistics 2016. URL: www.stats.oecd.org

¹⁴ OECD Health Statistics 2015. OECD converts local currency units to United States dollars (USD), using a purchasing power parity (PPP) exchange rate.

continuous improvements in the health services New Zealanders receive. The Ministry also works with sector partners to manage funds effectively.

The biggest challenge has been (and will be) to ensure that New Zealanders are continuously provided with excellent health care while ensuring the cost of our health sector is sustainable over the long term.

Public spending on health care has more than doubled as a share of GDP over the past 60 years, rising from 3.1 percent in 1950 to over 6 percent in 2015/16. This increase is typical of countries in the OECD. Vote Health continues to increase each year, but the rate of growth is slowing in line with this target. Real per capita growth in Vote health over the 10 years to 2015/16 was 14 percent, compared with the 25 percent 10-year growth target.

The Ministry of Health's high-level outcomes

New Zealanders are healthier and more independent

The Ministry wants a health system that improves, maintains and restores the health of the population within the available resources (where 'health' includes quality of life as well as length of life). To achieve that we are improving and strengthening the capacity of the health and disability system to protect and promote wellness, and we are constantly improving and monitoring the quality of health care provided to the public.

We want a health and disability system that does much more than treat people when they are ill: it also needs to focus on prevention and maintaining independence. We are protecting the overall health of the nation by minimising the risks of communicable diseases and environmental hazards, and by supporting people to manage their own health and wellbeing.

We are going to do this so that:

- the capacity of the health and disability system is improved and strengthened to protect and promote wellness, and the quality of health care provided to the public is constantly improving (and monitored)
- the overall health of the nation is protected by minimising the risks of communicable diseases and environmental hazards and by supporting people to manage their own health and wellbeing.

The public is supported to make informed decisions about their own health and independence

This will be achieved if the public is supported to protect, manage and improve their own health and independence; if people can access information and advice that promotes and helps manage risks to their health and wellbeing; and if families and whānau are involved in considering health issues and choices.

The results of burden of disease¹⁵ and health surveys¹⁶ are improved

New Zealand Burden of Disease Study: The Ministry has established an agreement for annual updating of the New Zealand Burden of Disease study with the Institute for Health Metrics and Evaluation (IHME), University of Washington, Seattle. The IHME produces the Global Burden of Disease estimates annually. By providing New Zealand-specific data to the study, and jointly conducting the statistical analysis and reporting with IHME, the Ministry will ensure that high-quality estimates and projections of health loss and health expectancy are available for monitoring population health and system performance. From 2016 subnational analysis by Māori and non-Māori ethnicity will be included (Ministry of Health 2016a).

New Zealand Health Survey: The New Zealand Health Survey (NZHS) is an important data collection tool for monitoring the health of the population. The survey provides evidence for health service planning, health policy and strategy development.

Data on a range of key survey indicators are published annually in December. Key indicators cover health status, health behaviours and risk factors, health conditions, access to health care, and oral health status for both children and adults. Reports on the survey results and further information about the NZHS can be found at the Ministry's website: www.health.govt.nz. The latest available data is for 2014/15.

In 2014/15, 16.6 percent of adults aged 15 years and over were current smokers (smoke at least monthly), which is 3.5 percentage points down from 2006/07. The rate of daily smoking for adults was 15.0 percent in 2014/15, which is 3.3 percentage points lower than in 2006/07. Similar declines in the rate of smoking occurred for men and women. The most substantial reduction in daily smoking since 2006/07 was for youth (aged 15–17 years), 5.8 percent of whom smoked daily in 2014/15 compared with 13.7 percent in 2006/07. In contrast, daily smoking rates for adults 45 years of age and over have not changed significantly since 2006/07.

A series of 10 percent tax increases (2010–2016) has already seen the price of the more expensive brands of cigarettes reach \$20 for a pack of 20. Yearly 10 percent tax increases will continue between 2017 and 2020, with the price for a pack of 20 cigarettes estimated to increase to \$30 by 2020. Tobacco consumption per capita has fallen by about 30 percent since 2009.

Improved smoking cessation support, the Government's 'Better help for smokers to quit' health target, continued media campaigns aimed at prompting quitting and encouraging youth not to start, and the introduction of plain packaging legislation will all continue to reinforce that smoking is not part of New Zealanders' future.

¹⁵ The New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016 (the New Zealand Burden of Disease Study) analyses health losses sustained by New Zealanders of all ages, both sexes and both major ethnic groups (Ministry of Health 2016).

¹⁶ The New Zealand Health Survey (NZHS) is an important data collection tool for monitoring the health of the population. A survey methodology report, the questionnaires and the content guides have been published. Further information about the survey can be found at the Ministry's website (www.health.govt.nz).

Selected New Zealand Health Survey indicators

Table 3: Selected New Zealand Health Survey indicators: unadjusted prevalence (%)

Among adults aged 15 years and over	2006/07 (percent)	2014/15 (percent)	Significance of difference (p-value) ¹⁷
Excellent, very good or good self-rated health	89.6	88.9	0.27
Hazardous drinking	18.0	17.7	0.40
Physically active	52.0	50.7	0.22
Obesity	26.5	30.7	0.00
Mood or anxiety disorder (diagnosed)	12.7	17.4	0.00
Unable to get appointment at usual medical centre within 24 hours	17.6	16.8	0.01

Eighty-five percent of new babies are enrolled with Plunket national Well Child/Tamariki Ora services¹⁸

Services are provided in conjunction with the Well Child Tamariki Ora National Schedule (June 2013) which outlines the assessment, intervention and health education activities for each of the eight universal core contacts. These are delivered to children and their families when the child reaches between four and six weeks of age, and continues until the child is five years old.

Target for daily smoking prevalence to fall to 10% by 2018 and the Māori and Pacific rates halve from their 2011 levels¹⁹ as part of Smokefree 2025²⁰

There has been no statistically significant decline in the rate of daily smoking for Māori and Pacific adults since 2006/07. With rates of 35.5 percent for Māori and 22.4 percent for Pacific adults, their rates remain considerably higher than those of non-Māori and non-Pacific adults.²¹

A B4 School Check is provided to 90 percent of the eligible population

A total of 57,985 children were checked during 2015/16 with a coverage of 92 percent of the total population and 93 percent of the high deprivation population. DHBs are currently funded to reach 90 percent of the total and high deprivation populations. Coverage for Māori and Pacific children was 88 and 89 percent respectively.

There is a reduced suicide rate for all ages²²

Suicide and suicidal behaviours continue to be a major public health issue in New Zealand. In 2013, 508 people (365 males and 143 females) died in New Zealand by suicide.²³ Overall, suicide

¹⁷ Note: a p-value less than 0.05 indicates a statistically significant difference between the two data points. P-values have been calculated using age-standardised prevalences, which take into account changing age structures in the underlying populations over time.

¹⁸ Plunket is contracted to provide approximately 85 percent service coverage. The balance of service coverage is by local providers contracted via DHBs.

¹⁹ In 2011/12, daily smoking prevalence was 16.4 percent for adults aged 15 and over. For Māori and Pacific peoples, the rates were much higher, at 38 percent and 22.7 percent respectively (Ministry of Health. 2012. *The Health of New Zealand Adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health).

²⁰ Government Response to the Report of the Māori Affairs Committee on Its Inquiry into the Tobacco Industry in Aotearoa and the Consequences of Tobacco Use for Māori (Final Response), March 2011.

²¹ Ministry of Health. 2015. *Annual Update of Key Results 2014/15: New Zealand Health Survey*. Wellington: Ministry of Health.

²² The Ministry leads the cross-government New Zealand Suicide Prevention Action Plan 2013–2016.

rates remained relatively stable between 2004 and 2013, ranging from 10.9 to 12.2 deaths per 100,000 population over this period.

Numerous factors influence a person's decision to take their own life or to self-harm. The number of suicides and self-harm hospitalisations can vary considerably from year to year, which makes it difficult to quantify the precise effect that programmes such as suicide prevention-related initiatives have on suicide and suicidal behaviour.

The current suicide prevention strategy and action plan end in 2016. Consideration is currently under way on the best approach to suicide prevention in recognition that suicide continues to be a major health and social issue in New Zealand. Actions will build on the current strategy and previous action plans and incorporate thinking and knowledge that have emerged since these were released. Because suicide prevention requires a multi-sectoral approach, the support and commitment from a range of government agencies will be essential. The first stage of a suicide prevention outcomes framework is complete. Implementation will be ongoing and will inform the approach to suicide prevention.

Waka Hourua, the national Māori and Pacific suicide prevention programme, has four components: National Leadership, National Māori Community Suicide Prevention, National Pasifika Community Suicide Prevention and Research and Evaluation.

The National Māori Community Suicide Prevention programme has appointed coordinators, who have supported the development and implementation of community suicide prevention plans in five DHB communities. They are in the process of working with several other DHBs to identify communities to work with. To support this work and other work, they have developed resources and training programmes for communities and organisations. They have also completed evaluation of 24 one-off-funded suicide prevention initiatives, and the results have indicated that, in the areas where the projects were run, Māori whānau have greater knowledge about suicide risk and increased understanding about accessing services.

The National Pasifika Community Suicide Prevention programme appointed 14 ambassadors in a number of communities of Pacific people in New Zealand. They have also developed appropriate suicide prevention training and resources, and media guidelines relating to suicide reporting, and have run training using the guidelines for Pacific people who work in the media.

Health and disability services are closely integrated with other social services, and health hazards are minimised

This will be achieved when more integrated health and social services make it easier for those with social needs to look after their health and independence, and when the public are protected from environmental and disease risk factors that lead to ill health. The following measures show how well we are doing.

The annual influenza programme of 1.2 million doses of flu vaccine is delivered

The Ministry monitors the volume of influenza vaccine doses distributed annually. The seasonal influenza immunisation programme ends on 31 August 2016. Currently 1,230,700 doses of influenza vaccine are distributed. Business object reports are available to measure DHB and PHO coverage by age and ethnicity. The final number of over-65-year-olds immunised cannot be confirmed until late October, when all immunisation claims have been submitted for payment.

²³ www.health.govt.nz/publication/suicide-facts-2013-data

Health and disability services are closely integrated with other social services

This was a new measure in 2014/15. It drew on the report *Delivering Social Services Every Day: Changing how we work together to support New Zealanders* (Ministry of Social Development, May 2014) published on behalf of social sector agencies. Further such reports were expected, but the report has not been updated.

The incidence of rheumatic fever rates is reduced by two-thirds to 1.4 cases per 100,000 people by June 2017

The latest figures from the Ministry's Rheumatic Fever Prevention Programme show a 37 percent decrease in first-episode rheumatic fever hospitalisations since the target was introduced in 2012. So far 3418 eligible families have been referred to the Healthy Homes Initiatives, with more than 2838 interventions supplied. The initiatives are in all 11 DHBs with a high incidence of rheumatic fever.

Priority populations (Māori, Pacific or Quintile 5) understand the cause of rheumatic fever, how to prevent Group A streptococcal throat infections and how to access care in a timely manner, including:

- the Pacific Engagement Strategy: 30,000 families engaged through in-home visits and community events in Auckland and Wellington
- Māori Community Fund delivered to the six highest DHB Māori communities
- advertising campaigns in winter 2016.

Eighty percent of at-risk children and young people have free and rapid access to effective sore throat management services and appropriate utilisation of school-based programmes and rapid response clinics.

High-quality health and disability services are delivered in a timely and accessible manner

We are seeking to achieve a health system that is people-centred and more convenient: a high-quality system that meets people's health needs and their legitimate expectations, and that New Zealanders have confidence in. We are doing this so that clinical integration of health services delivers a better health care experience to New Zealanders, which will mean strong coordination at every level of the health and disability system to ensure the different parts work well together. In this way, the sector will work together to provide health and disability services across organisational and disciplinary boundaries so that patients receive the best possible care. Sector coordination contributes to efficiencies across the system and ensures a similar level of care for patients, regardless of where they live.

The public can access quality services that meet their needs in a timely manner, where they need them

This will be achieved when the public have access to quality services and the health and disability system is supported to embed sustainable improvements in service delivery. Harm from the use of alcohol, tobacco and other drugs will be minimised, and monitoring sector performance and communicating that information will provide the public with confidence and trust in the sector. The following measures show how well we are doing.

Infant mortality rates continue to decrease from a baseline of 4.8 deaths per 1000 live births in 2009

Infant mortality was 5.0 per 1000 live births in 2013.

Serious and sentinel events reduce from a baseline of 374 in 2009/10

These are adverse events that have generally resulted in harm to patients. DHBs report information on such events for the previous year to the Health Quality & Safety Commission (HQSC). The numbers for 2015/16 are: 520 'general' events (525 in 2014/15)²⁴ and 185 mental health cases²⁵ (185 in 2014/15). The increase in numbers since the baseline of 2009/10 is thought to be a result of improved reporting rather than an actual increase.

Further information is available on the HQSC website (www.hqsc.govt.nz/our-programmes/adverse-events/serious-adverse-events-reports/)

There is reduced amenable mortality²⁶

The amenable mortality rate has decreased by 29 percent over the last 10 years (from 132.0 per 100,000 people aged 0–74 years in 2004 to 93.5 per 100,000 in 2013). The decrease was evident across all ethnic groups. The largest decline has been seen for Māori, with the amenable mortality rate falling by almost one-third (32 percent). However, in 2013 the amenable mortality rate was still 2.8 times higher for Māori and 2.4 times higher for Pacific people, compared with non-Māori, non-Pacific people.

The overall quality score in the health group continues to improve (2007: 68; 2009: 69; 2012: 72; 2013: 73), as measured through the Kiwis Count Survey

The State Services Commission report (see www.ssc.govt.nz/kiwis-count) has not been updated for 2015/16.

Personalised and integrated support services are provided for people who need them

This will be achieved when integrated, effective, affordable, people-centred health services for people with disabilities, including older New Zealanders, are provided so that they can remain living in their homes longer and can live healthier and more independent lives. The following measures show how well we are doing.

There is a reduced incidence of falls²⁷

There were 65 in-hospital falls resulting in fractured neck of femur (broken hip) in the 12 months ending March 2016. This is a reduction of 44 falls compared with the expected number of 109 falls given the rate observed in the baseline of July 2010 to June 2012. We also see a downward shift in falls in hospital causing other kind of fractures: 204 in the year ending March 2016, which is significantly lower than the 240 falls we would have expected in this year, given the median quarterly result (60 falls) observed in the period from July 2012 to June 2014.

This result is also supported in the HQSC's serious adverse event data. In the period 1 July 2015 to 30 June 2016, all falls-related serious adverse events reported by DHBs reduced from 277

²⁴ Reported as 510 in the 2014/15 Annual Report.

²⁵ Results are for January to December 2015.

²⁶ Deaths from those conditions for which variation in mortality rates (over time and across populations) reflects variation in the cover and quality of health care (preventive or therapeutic services) delivered to individuals.

²⁷ 'Falls' refers to incidents that required hospitalisation for older people (not serious and sentinel events).

(2014/15) to 194. Within the data, reported falls resulting in fractured neck of femur decreased from 84 (2014/15) to 68.

In the last 18 months there has been a cross-agency work programme between HQSC, ACC and the Ministry. As of July 2016 a significant injection of expenditure is being made by ACC to support efforts to reduce falls and harm from falls over the next three years (\$30 million). Aligned with this is a common 'outcomes framework', which the parties are largely in agreement about, to use as a measure of progress. There may be some changes to wording, but the measures have been chosen to be easily obtainable, reliable and durable (with a 5- to 10-year timeframe to consider given the nature of the interventions).

The work to establish relatively easily obtained metrics is largely complete. The measures are too numerous and detailed for an annual report, but an executive summary is likely to be developed. We intend to use this in all reports from the contributing agencies.

One of the measures that reflects the previous annual reports is 'Number of hospital admissions for a fall'. This will be derived from the ACC claims and cross referenced with National Minimum Dataset (Hospital Events) data. It is likely to be a good surrogate of success and relatively independent of other activities that have an impact on the type of events associated with admission to hospitals.

There is a reduced prevalence of people in the 65-plus-years age group with dependent disability

The measure has been redefined as follows: a reduction in the proportion of older people requiring residential care; and rate of acute hospital use.

A key focus in the sector is on improving the independence of older people. There is good evidence older people who continue to live in their own home, with support from home and community support service providers if necessary, experience greater wellbeing. Most older adults prefer to stay in their own home, and this arrangement is also usually less expensive than residential care. The aim is to reduce the proportion of older people requiring residential care services.

In 2015/16 the number of people aged 75 and over in residential care was 28,503, an increase of 2,146 since 2006/07.²⁸ This represents a decrease in the proportion of older people requiring care from 11 percent to 10 percent.

The rate of acute hospital bed days is a measure of how effectively health system resources are being used. This rate may be affected by the quality of primary care, discharge planning and ongoing communication about a person's care between hospital and community care. The corresponding aim is to reduce the rate of acute hospital use.

Acute hospital service use in New Zealand by people aged 65 years and over was estimated as 1.11 million bed days in the year ending March 2013/14.²⁹ This represents an average of about 2.8 bed days per person for the year. In the year ending March 2015/16 the rate had fallen to an estimated 2.55 bed days per person and 1.08 million total bed days for the year.

²⁸ Aged residential care (ARC) numbers are derived from the demand planner that DHBs and providers are able to use to predict future demand for ARC services. See <http://centraltas.co.nz/health-of-older-people>

²⁹ Ministry of Health system-level measure.

Ethnic health disparities are reduced³⁰

Ethnic health disparities have reduced as health outcomes have improved, but challenges still exist.

- From 2004 to 2013 amenable mortality rates decreased across all ethnic groups. In absolute terms the greatest decline was seen for Māori, followed by Pacific people. In relative terms, however, inequality increased for Māori and remained stable for Pacific people: in 2013 rates for Māori were 2.8 times higher, and rates for Pacific people 2.4 times higher than for non-Māori and non-Pacific people. The most common conditions contributing to deaths amenable to health care vary by life stage but are largely consistent between ethnic groups.
- Smoking is strongly associated with neighbourhood deprivation. In 2014/15 the rate of daily smoking was 25.4 percent in the most deprived areas, compared with 8.3 percent in the least deprived areas (Ministry of Health 2015). This variation was not due to differences in the demographic mix across neighbourhoods, because after adjusting for differences in age, sex and ethnicity, adults living in the most deprived areas were 3.4 times more likely to be daily smokers than adults living in the least deprived areas.
- The Māori and Pacific infant mortality rates (5.7 and 6.9 per 1000 live births, respectively) remained higher than the rate for the Asian and European or Other ethnic groups in 2012 (2.9 and 4.1 per 1000 respectively).³¹

The proportion of people with a K10 score³² ≥ 12 is reduced (an indicator of mental illness, such as anxiety or depressive disorder)

A K10 score of 12 or more indicates high or very high levels of psychological distress. Where people experience these levels of psychological distress there is a high probability that they have an anxiety or depressive disorder. In 2014/15 it was estimated that 225,000 adults had a K10 score of ≥ 12 . This represents 6.2 percent of the population, compared with 6.6 percent in 2006/07, indicating no statistically significant change.

Men are less likely to report having experienced psychological distress in the last four weeks than women. In 2014/15, 4.6 percent of men and 7.6 percent of women had a K10 score of ≥ 12 . After adjusting for age and sex differences, Māori and Pacific adults were 1.6 times more likely to report having experienced psychological distress than non-Māori and non-Pacific adults, respectively. Adjusted for age, sex and ethnic differences, adults living in the most deprived areas were 3.0 times more likely to report having experienced psychological distress than those living in the least deprived areas. This is up from 1.7 times more likely in 2013/14.

Health services are clinically integrated and better coordinated

This will be achieved when a significant contribution has been made to the Better Public Services results, and when coordination throughout the health sector is improved and strengthened. The following measures show how well we are doing.

³⁰ Although the national picture of health is positive, there are substantial variations in outcomes for different populations, particularly Māori, Pacific people and those living in more socioeconomically deprived areas, eg, rates of some illnesses (eg, rheumatic fever and skin infections) are much higher among Māori and Pacific people.

³¹ Source: www.health.govt.nz/publication/fetal-and-infant-deaths-2012.

³² A 10-item questionnaire intended to yield a global measure of distress, based on questions about anxiety and depressive symptoms.

DHB performance against planned integration activities³³

The Ministry monitored DHB performance against planned integration activities, including shifting services closer to home, integrated acute demand planning, and the development of clinical pathways – Counties Manukau, Canterbury and MidCentral DHBs continue to lead the way in this area. The Ministry also continued to work with DHBs to implement and increase the functionality of the Maternity Clinical Information System, which is in use in five DHBs.

The number of assaults on children decreases

In 2015/16, the Ministry undertook the following work.

- Provided implementation support and funding to establish all 10 children's teams, including new teams in Hamilton, Tairāwhiti, Eastern Bay of Plenty, Whanganui, Christchurch, and Counties Manukau.
- Contributed to the 'Hub' contact and triage point, and the Vulnerable Kids Information System (ViKI) which are now operational in the Christchurch, Hamilton and Counties Manukau Children's Teams.
- Developed and agreed, with other agencies, the Vulnerable Children's Approved Information Sharing Agreement.
- Supported the health sector to implement the requirements of the Vulnerable Children Act 2014, including the development of a cross-agency safety checking service for self-employed children's workers.
- Contributed to the review and publication of the second edition of the Guide to Effective and Safe Practice in Youth Mentoring.
- Supported DHBs to adopt the National Child Protection Alert System (NCPAS) to alert DHB health professionals to child protection concerns when children arrive at hospital. Currently 19 out of 20 DHBs are approved to use the system.
- Worked with DHBs, the New Zealand Police and Child, Youth and Family to develop new draft schedules to the existing Memorandum of Understanding. The purpose of this memorandum is to set out the commitment to collaborate and to ensure health and safety outcomes for children and young people are met. The draft schedules establishes the basis for how the parties will work together at district, regional and national levels on cases of Medical Neglect and for the management of children exposed to a Clandestine Laboratory.
- Published the Family Violence Assessment and Intervention Guideline. This is the foundation document for the Ministry's response to intimate partner violence and child abuse and neglect, and in particular the Violence Intervention Programme. The Guideline was published in 2002 and has now been updated and was launched by the Minister of Health on 16 June 2016.

Personal health information is readily available to patients and clinicians, no matter where care is delivered³⁴

The Digital Health Work Programme aims to ensure that personal health information is available to patients and clinicians, no matter where care is delivered, through smart use of digital health solutions.

DHBs are implementing regional IT systems that enable clinicians to access clinical information at the point of care. DHB systems have been benchmarked against an international methodology to assess and increase acute hospitals' digital maturity, which, when fully achieved, will greatly

³³ Includes shifting services closer to home, integrated acute demand planning and the development of clinical pathways.

³⁴ Reported against the National Infrastructure and Information Systems work programme for system integration, the health information platform, leveraging health identity, and IT infrastructure and platforms.

increase their ability to record and share clinical information electronically. This includes compliance with common standards needed to share information.

All regions have implemented eReferrals, eDischarges, clinical pathways and GP2GP, which allows the sending of patient notes from one GP to another when a patient moves to another practice. More and more patients are also accessing their own health information via patient portals, and this is enabling them to manage their own health care. The establishment of a single electronic health record (EHR) will also significantly support the sharing of health information.

The future sustainability of the health and disability system is assured

We are seeking to achieve a health and disability system that provides the necessary care and services in an economically sustainable way over the long term such that the rate of growth of health spending is managed to deliver the best services in an affordable way. We are doing this so that the health and disability system ensures effective financial management, fosters improvements in productivity, puts in place regional and national planning where appropriate, and ensures the development of our workforce and IT infrastructure is coordinated and rationalised across the country.

The health and disability system is supported by suitable infrastructure, workforce and regulatory settings

Annual number of postgraduate trainees is 5000 trainees and 1900 training units

The number of postgraduate trainees trained in 2015/16 was 5587 trainees and 1888 training units. This compares with 5369 trainees and 1826 training units in 2014/15.

Actual 2014/15	Type of Training	Actual 2015/16
	Post-entry clinical trainees funded	
752	• Non-vocational medical	780
1,269	• Vocational medical	1,146
178	• Technician medical	148
283	• General practice	305
14	• Clinical Rehabilitation Certificate	27
1,161	• Nursing entry to practise	1,151
161	• Midwifery	280
269	• Hauora Māori	249
180	• Pharmacy internship	180
298	• Mental health workforce development	538
175	• Mental health MeHD training	163
629	Voluntary Bonding Scheme registrants who have successfully made a claim for payment	620
5,369	Total post-entry clinical trainees funded	5,587
	Funded training units delivered:	
1,526	• Postgraduate nursing	1,588
300	• Māori and Pacific peoples support	300
1,826	Total training units delivered and funded:	1,888

More detail on the post-entry training will be shown in the Minister of Health's *Vote Health: Report in relation to selected non-departmental appropriations for the year ended 30 June 2016*.

Health-related legislation is reviewed and updated as required

After an extensive policy development process, public consultation, two rounds of consideration by Cabinet and a thorough parliamentary process, New Zealand's 1965 legislative framework for radiation was brought into the 21st century in March 2016 with the passage of the Radiation Safety Act 2016. The new Act, which enters fully into force in March 2017, aims to protect the health and safety of people and the environment from the harmful effects of ionising radiation while allowing the safe and beneficial use of radiation sources. Although the majority of use occurs in the health sector, where radiation is used for both diagnosis and treatment, it is also used in commercial/industrial, research and veterinary applications.

The new Act introduces a comprehensive licensing framework as well as establishing a series of fundamental requirements with which all those involved with radiation sources will need to comply. The Act also allows New Zealand to meet its international obligations on radiation security and nuclear non-proliferation.

Following policy approval in 2013, important amendments to the Health Act 1956 were passed in June 2016 through the Health (Protection) Amendment Bill. These amendments update the Act's provisions for the surveillance and control of infectious diseases, and include provisions to support the internationally recognised practice of contact tracing. In addition, the amendments will introduce a ban on the provision of artificial UV tanning services (sunbeds) to persons aged under 18 years of age. These amendments will enter into force in January 2017.

Integrated IT and security programmes are delivered³⁵

Integrated national and regional systems are being implemented across the hospital, primary health care and community sectors. DHBs are implementing regional clinical information systems that allow clinicians to access trusted information at the point of care. Primary care recording of health information is largely electronic, and more practices are implementing portals that allow consumers to access their own health information. The transfer of information across the sector is enhanced with the use of electronic referrals from general practice to hospitals and electronic discharge summaries from hospitals to general practice.

Security and audit controls are built into systems. The sector is required to comply with the Health Information Security Framework (HISF) to ensure health data are adequately protected. Vendors are required to develop systems to standards approved by the Health Information Standards Organisation (HISO).

Quality, efficiency and value-for-money improvements are enhanced

This will be achieved when service efficiencies are identified and ways are found to increase value and manage overall cost growth. DHBs will be supporting system integration and creating efficiencies by working together in an intentional, collaborative way. Services will be planned, funded and provided to ensure the clinical and financial viability of a safe, high-quality public health and disability service. A cost-effective, sustainable health sector will focus on quality improvement and safety, providing value for money and effective health interventions to improve New Zealanders' health status. The following measures show how well we are doing.

³⁵ The National Health IT Plan outlines the priority programmes required to deliver this target.

Target for DHBs' forecast deficits to reduce from a baseline of \$23.4 million (set in 2011/12)

The overall performance result was a net deficit of \$55 million, which was \$35 million above budget. In 2014/15 the overall performance result was a net deficit of \$68 million, which was \$32 million above budget.

Target for DHBs to manage within their budgets, collectively

Eleven DHBs were unfavourable to plan: Bay of Plenty, Canterbury, Capital & Coast, Hutt Valley, Lakes, MidCentral, Nelson Marlborough, South Canterbury, Tairāwhiti, Taranaki and Wairarapa. Ministry has used its monitoring and intervention framework to work with DHBs identified as having performance issues, including deficits. These DHBs are being regularly monitored.

NZ Health Partnerships Limited (HPL) established

HPL was established on 1 July 2015 with the aim of enabling DHBs to collectively maximise shared service opportunities for the national good.

Ministerial advisory committees are supported

The results from the July 2016 Survey of Chairs and Deputy Chairs, measuring satisfaction with the support provided to committees by the Ministry, are shown below. The overall satisfaction with the support provided to committees by the Ministry in the past 12 months was 3.9.

Very satisfied (5)	Satisfied (4)	Neither satisfied nor dissatisfied (3)	Dissatisfied (2)	Very dissatisfied (1)	Average Score
How satisfied are you with the quality of analysis, information, advice, committee papers and reports (ie, non-administrative support) provided over the past 12 months?					
9	4	0	1	0	4.5
How satisfied are you with the administrative support provided to you over the past 12 months, including meeting arrangements and timeliness/quality of papers?					
6	4	3	1	0	4.1
Overall, how satisfied are you with the overall support provided to your committee by the Ministry in the past 12 months?					
6	4	1	2	1	3.9

Statement of performance

Introduction

This section outlines the Ministry's performance and meets the requirements of the Public Finance Act 1989. Performance measures enable the reporting of the quantity, quality, timeliness and cost-effectiveness of the Ministry's outputs. The measures also provide key information about the Ministry's overall performance and role. The performance measures show the Ministry's outputs against the performance measures from the Estimates.

This section groups and presents the Ministry's performance measure results by appropriation within Vote Health. The Ministry has met or exceeded most of its targets; explanations are provided if the variance is greater, or less than, 10 percent. A number of the targets not achieved were demand-driven results.

Table 4: Summary of service performance measures, by departmental expense appropriation

	Total measures	Targets achieved	Targets not achieved
Health sector information systems	5	5	0
Managing the purchase of services	6	5	1
Payment services	15	10	5
Regulatory and enforcement services	14	11	3
Sector planning and performance	11	9	2
Policy advice and ministerial servicing (MCA)	7	5	2
Total	58	45	13

Health sector information systems

The Ministry operates and manages IT infrastructure that underpins national data collections and systems used in service delivery. As part of this the Ministry manages the national collections that provide access to information and coded data. This enables the health and disability system to undertake local, regional and national planning of resources for current and future service demand.

In addition, frontline health-sector staff use systems such as the NHI to identify patients in real time and make sure they get appropriate services and support.

Table 5: Summary of output performance measures and standards for health sector information systems

Actual 2014/15	Performance measure	Standard	Actual 2015/16
National infrastructure and systems			
99.5%	The percentage of time for which key sector- and public-facing systems are available	99%	99.9%
15,500	The number of active user logins to national systems	10,000	14,990 (see Note A)
National collections			
16	The number of national collection reports produced annually	10	13
100%	The percentage of data submitted by DHBs that is processed within two working days	97%	99.7%
3082	Number of requests, for data and/or analysis, responded to in respect of information held within the national collections datasets	2900	3109

National infrastructure and systems

Six key systems are used widely across the health sector. These are:

- the National Health Index (NHI)
- the National Immunisation Register (NIR)
- online pharmacy claiming
- special authorities
- the Oracle financial system
- the Ministry's website.

Disruptions in service are unproductive and would damage the Ministry's reputation. In 2015/16 all systems were available for almost 100 percent of the time.

Note A: Information from national systems was available to almost 15,000 external user accounts with log-in access to the systems. An active user is either an individual user or an organisation. The number of active user log-ins has continued to grow over the last few years, so the budget standard for 2016/17 has been increased to 15,000.

National collections

The national collections provide valuable health information to support decision-making in policy development, funding, monitoring and research. This information contributes to improving the health outcomes of New Zealanders. Information from the national collections was used to publish 13 reports (available at www.health.govt.nz/publications).

In 2015/16, 99.7 percent of the data submitted by DHBs relating to the National Minimum Dataset (NMDS) (hospital events) and the National Booking and Reporting System (NBRS) (patients waiting for elective surgery) was processed within two working days of receipt. The Ministry is committed to the efficient and accurate processing of data. The Ministry also provides information services to the public.

Table 6: Financial performance for health sector information systems

Actual 30/06/2015 \$000		Actual 30/06/2016 \$000	Main Estimates 30/06/2016 \$000	Supp. Estimates 30/06/2016 \$000
50,673	Revenue Crown	50,661	50,201	50,661
31	Third-party revenue	0	0	0
50,704	Total revenue	50,661	50,201	50,661
50,338	Total expenditure	50,109	50,201	50,661
366	Net surplus	552	0	0

Managing the purchase of services

The Ministry has a significant responsibility for purchasing health and disability services on behalf of the Crown. A total of \$11.861 billion of funding was provided to DHBs and health-related Crown entities in 2015/16, and the Ministry purchased \$2.681 billion worth of services directly through non-departmental funding.

This output class assesses how well the Ministry negotiates and manages a portfolio of contracts within its purchasing and pricing frameworks to deliver consumer-focused services while ensuring value for money. The output also ensures there is a consistent national approach to providing support services to people in need.

Table 7: Summary of output performance measures and standards for managing the purchase of services

Actual 2014/15	Performance measure	Standard	Actual 2015/16
	Contracting		
4061	Total number of contracts held by the Ministry for the purpose of purchasing goods and services on behalf of the Crown	4300	4018
Achieved	The Ministry Procurement Policy is assessed and confirmed to be in line with government standards	Achieved	Achieved
1:75	The ratio of departmental expenditure for the output class against relevant non-departmental expenditure	1:80	1:105 (see Note A)
	Contract management		
New	Social agencies are required to move contracts with NGOs to the streamlined contract framework as they are renewed. The Ministry will move the following numbers of contracts by 30 June 2016	320	333
92%	The percentage of Ministry feedback to Crown Funding Agreement Variation (CFAV) monitoring reports that are supplied to DHBs within agreed timeframes	90%	100%
100%	The percentage of complaints from service users received by the National Quality Group, National Services Purchasing and National Health Board that receive a timely initial response from the Ministry	95%	96.7%

Contracting

These measures capture dimensions of the work being undertaken in actively purchasing services using non-departmental expenditure (NDE) on behalf of the Crown. The following are defined as contracts for the purpose of these measures:

- any contract that has any dollar value and is managed under the Ministry's Non-Departmental Contract Management System, or
- payments made under section 88 of the New Zealand Public Health and Disability Act 2000, or
- payments managed by the Ministry's client claims processing system.

The measure does not include Crown Funding Agreements (CFAs) with the DHBs.

Contracts are held between the Ministry and other parties, on behalf of the Crown, for purchasing services for third parties. Such contracts are always paid from NDE appropriations. Included in the scope of these contracts are:

- new (or renewed) contracts supporting national service purchasing (eg, the National Screening Unit, disability support services, ambulance services, maternity services and public health services)
- other new (or renewed) contracts entered into by the Ministry for providing services to external parties using NDE funding.

The Ministry reviews its own procurement policy and standards to ensure compliance with government standards, as required.

Note A: The ratio of departmental expenditure and relevant NDE measure assesses how efficiently the Ministry manages its contracted NDE of \$2.702 billion, which is a component of the total \$2.786 billion Ministry-managed NDE. The target is to have the Ministry manage \$80 worth of contracted NDE for every dollar of related departmental expenditure spent. In 2015/16 the Ministry exceeded the target by managing \$105 contracted NDE for every dollar it spent (\$75 in 2014/15). The change in values from 2014/15 is because in previous years the disability service client claims were not included in this measure; if the figure was adjusted for 2014/15 it would have been 1:107.

Contract management

The contract management performance measures assess how well the Ministry handles monitoring information. They act as a proxy for measuring the quality of contract performance management. Regular feedback to providers on contractual performance assists in both preventing poor performance and efficiently resolving existing performance issues. This measure applies to all monitoring reports sent to the Ministry by contracted service providers according to a regular reporting schedule, such as would normally be expected in a contracting arrangement. Reports may be sent monthly, quarterly or according to some other schedule.

The following reports are excluded from the measures:

- monitoring reports for contracts where the total value of the contract is below the financial threshold
- CFA variation monitoring reports
- extraordinary correspondence, issues management and other performance reporting outside the normal contractual schedules for reporting.

'Service providers' include all organisations that have a contract with the Ministry to deliver services funded from the NDE budget.

The measure 'Social agencies are required to move contracts with NGOs to the streamlined contract framework' was new for 2015/16. Phase Three of this project is ongoing and includes the period 1 July to December 2016, with implementation continuing in accordance with the agreed time frames listed in the plan. Targets will be increased as follows: 2015/16: 320; 2016/17: 800; 2017/18: 840; 2018/19: 900.

Crown Funding Agreement variations (CFAVs) comprise a significant amount of contracting activity. The Ministry monitors these contracts in a different way, according to their own rules and tracking system. CFAV monitoring reports are typically short confirmations of the funding that has been spent, along with some associated measures, such as volume of a service delivered and number of people employed. These reports are usually due on the 20th day of the month following the end of the quarter. A key facet of this system is that monitoring reports from DHBs should receive feedback from the Ministry within a standard timeframe of 14 business days. This year, all feedback to DHBs in relation to CFA variation monitoring reports was delivered on time.

Table 8: Financial performance for managing the purchase of services

Actual		Actual	Main	Supp.
30/06/2015		30/06/2016	Estimates	Estimates
\$000		\$000	30/06/2016	30/06/2016
			\$000	\$000
32,918	Revenue Crown	32,626	30,807	32,626
0	Third-party revenue	0	0	0
32,918	Total revenue	32,626	30,807	32,626
31,252	Total expenditure	31,790	30,807	32,626
1,666	Net surplus/(deficit)	836	0	0

Payment services

The Ministry is responsible for administering core health payment processes for the health and disability system, including administering agreements between health funding organisations and health providers, managing the subsequent payment of funds, and capturing and tracking health care users' entitlements and usage. The Ministry operates telephone contact centres that handle queries and service requests from funders, providers and health care users in support of the payment services function. The Ministry also carries out audit and investigation activities on payments made across the health and disability system.

Table 9: Summary of output performance measures and standards for payment services

Actual 2014/15	Performance measure	Standard	Actual 2015/16
	Claim transactions		
1,744,780	The number of claims processed per annum	1,800,000	1,775,576
100%	The percentage of claims paid on time	95%	99.8%
99%	The percentage of claims processed accurately	95%	99.1%
\$2.53	The direct cost per claim transaction processed	\$2.70	\$2.24
	Agreements		
11,582	The number of agreements processed per annum	9400	9123
86.5%	The percentage of all draft agreements prepared for funders within target timeframes	95%	80.1% (see Note A)
93.4%	The percentage of agreements prepared accurately	95%	97.1%
\$83.23	The cost per agreement processed	\$155.00	\$104.87 (see Note B)
	Contact centres		
501,528	Number of contact centre calls per annum	500,000	454,444 (see Note C)
68.8%	The percentage of calls to contact centres answered within service specifications for timeliness (20 seconds currently)	80%	81%
5%	The percentage of calls abandoned by callers prior to being answered by the contact centre	<5%	2.5%
\$4.61	The cost per enquiry	\$4.70	\$4.53
89%	The percentage of enquiries resolved in under 10 business working days	95%	96.9%
	Financial audit and compliance activities		
90%	The total dollar value of payments made to those primary health and disability providers who have been subject to audit and compliance activities during the year, expressed as a percentage of the budget for those providers	70%	94% (see Note D)
0%	The total number of Ministry-prosecuted cases against the percentage of those cases that contain adverse judicial comments	<10%	0%

Claim transactions

The Ministry pays a variety of health and disability system providers, such as midwives and pharmacies, typically in response to claims from those providers. Claims include all transactions where payment is required, including registrations, invoices and other support claims. The Ministry aims to deliver the service as efficiently as possible.

Ongoing improvements made to the health payment systems have seen the volume of manual claiming reduced in recent years. The number of claims processed is a demand-driven measure and the volume for 2015/16 is at a similar level to that in the previous year.

Agreements

This area covers all agreements administered where a service is provided to the sector. It includes contracts between funders (either the Ministry or DHBs) and service providers, but excludes CFAs and their variations, since these are administered outside the payment services systems.

The decrease in the total number of agreements processed, compared to the previous year, was due to the additional variations to the age-related residential care services agreements that were processed in 2014/15.

Note A: The timeliness target has not been met, mainly due to the high demand for agreement services at the start of each financial year, which affected the overall result.

Note B: The year-end cost per agreement processed of \$104.87 exceeded the target of \$155.00 by 32 percent due to the high volume of agreement requests.

Contact centres

The National Contact Centre (NCC) supports the health and disability system and the wider public by responding to health-related enquiries in approximately 60 areas, including carer support, pharmacy, the NHI and the Ministry's general line. Ministry-funded outsourced contact centre work (such as that provided by PlunketLine, Healthline and Quitline) is excluded from the measures reported here.

Note C: The number of contact centre calls per annum is a demand-driven measure. The volume of calls decreased from the previous year due to the roll-out of the Online Identity Services, which reflects the improvement in responsiveness to calls as a result of the clustering initiative put in place.

The decrease in calls volume and the new initiative have resulted in meeting the percentage of calls to contact centres answered within service specifications for timeliness (20 seconds currently) for the first time in five years. The target percentage of calls to contact centres answered within 20 seconds has been increased to 90 percent for 2016/17.

Financial audit and compliance activities

Note D: The Ministry undertook audit activities in relation to a sample of 94 percent of the funding of \$6.6 billion worth of sector services payments for 2015/16 across 14 funding streams. The target has been increased to 80 percent for 2016/17.

The Ministry continues to work on improving compliance and preventing fraud in the health sector. This is a cost-effectiveness measure for the Ministry's audit activities on sector financial payments. As a result of the 2015/16 audit and investigation activities, the Ministry identified \$5.7 million worth of recoverable losses and averted \$11.5 million worth of future losses.

Any adverse judicial commentary is in regard to the evidential basis for bringing a case before the Court and/or whether the matter was sufficiently serious to warrant the intervention of the criminal law. In 2015/16 there were two concluded prosecutions, neither of which was subject to any adverse judicial comment.

Table 10: Financial performance for payment services

Actual		Actual	Main	Supp.
30/06/2015		30/06/2016	Estimates	Estimates
\$000		\$000	30/06/2016	30/06/2016
			\$000	\$000
17,326	Revenue Crown	17,677	17,549	17,677
0	Third-party revenue	0	622	
17,326	Total revenue	17,677	18,171	17,677
17,908	Total expenditure	17,907	18,171	17,677
(582)	Net surplus/(deficit)	-230	0	0

Regulatory and enforcement services

The Ministry is responsible for a range of core regulatory functions within the health sector. Various sections within the Ministry have specific areas of responsibility. These include:

- the New Zealand Medicines and Medical Devices Safety Authority (Medsafe), which is responsible for the regulation of therapeutic products
- the Office of Radiation Safety, which is responsible for the regulation of ionising radiation
- HealthCERT, which is responsible for ensuring hospitals, aged residential care providers (including rest homes), residential disability care providers and fertility service providers provide safe and reasonable levels of service for consumers
- Medicines Control, which is responsible for the regulation of the local distribution chain of medicines and controlled drugs within New Zealand
- the Psychoactive Substances Regulatory Authority, which is responsible for the operation of the Psychoactive Substances legislation
- the Public Health Group, which is responsible for the administration of legislation protecting people from communicable disease and environmental health risks.

The Ministry carries out several key statutory functions related to health protection. These include the roles of the Directors of Public Health and Mental Health, which both carry important leadership and decision-making responsibilities, including interpreting and administering the relevant legislation. The Ministry also supports a range of ministerial committees.

Table 11: Summary of output performance measures and standards for regulatory and enforcement services

Actual 2014/15	Performance measure	Standard	Actual 2015/16
	Compliance		
	Number of quality audits of providers conducted or assessed:		
633	• total	664	670
51	• Medsafe	37	34
346	• HealthCERT	267	275
266	• Medicines Control	360	361
	Implementation		
98%	The percentage of medium- and high-priority quality incident notifications relating to medicines and medical devices that undergo an initial review within 5 working days	90%	99%
72%	The percentage of all certificates issued to providers under the Health and Disability Services (Safety) Act 2001 within 20 working days of the receipt of all information and payment of the required fee	90%	91%
93%	The percentage of all licences and authorities issued to providers under the Medicines Act 1981 and Misuse of Drugs Act 1975 within target timeframes	90%	91%
100%	The percentage of all licences and consents issued to radiation users under the Radiation Protection Act 1965 within 10 working days of the receipt of all information and payment of the required fee	90%	100%
88%	The percentage of all New Medicines Applications (for ministerial consent to market) that receive an initial assessment within 200 days	80%	78%
100%	The percentage of all Changed Medicines Notifications (for ministerial consent to market) responded to within 45 days	100%	100%

Actual 2014/15	Performance measure	Standard	Actual 2015/16
	Sector leadership and advice		
Achieved	All statutory officers appointed by the Ministry meet the criteria set by the Director-General of Health and any statutory prerequisites for appointment	Achieved	Achieved
	Statutory committees and regulatory authorities		
100%	All recommendations for appointments meet the requirements of health legislation	100%	100%
57	The number of appointments to statutory committees and regulatory authorities	107	217 (see Note A)
100%	The percentage of recommendations for appointments where recommendations are presented to the Minister prior to expiration of term for the current appointee	95%	100%
4.1	Average rating for statutory committee satisfaction with secretariat services provided by the Ministry	>4 out of 5	3.9 (see Note B)

Compliance

The Ministry conducts quality audits of pharmacies licensed under the Medicines Act 1981 and reviews surveillance audits performed by designated auditing agencies for providers certified under the Health and Disability Services (Safety) Act 2001. It also audits manufacturers and packers of medicines. The Ministry conducts quality audits to ensure providers of health care services continue to improve the quality of their services beyond formal licensing/certification.

The Ministry receives and responds to complaints made under the Health and Disability Services (Safety) Act 2001 against certified hospitals, rest homes, mental health facilities and residential disability services. Complaints are tracked and an initial response is provided within seven working days where the complaint was received by the HealthCERT team in the Ministry. If complaints are initially received by the Health and Disability Commissioner or DHBs, those agencies are responsible for providing the initial response to the complainant.

Implementation

Hospitals, rest homes, residential disability care providers and fertility providers are certified under the Health and Disability Services (Safety) Act 2001. Under that Act the expected timeframes for certification are within 20 working days of receipt of all information and payment of the required fee.

Pharmacies and other parties involved in the pharmaceutical supply chain (such as wholesalers and researchers) are licensed to handle medicines and drugs under the Medicines Act 1981 and the Misuse of Drugs Act 1975. Providers are licensed to use and possess radioactive substances under the Radiation Protection Act 1965. When certificates are issued in accordance with legislative requirements the key operational measure is timeliness. This is the principal dimension of service quality, particularly when viewed from the customer perspective. Issuing certificates is central to the Ministry's regulatory activity.

Sector leadership and advice

The Ministry is involved in a range of regulatory, leadership and purchasing roles aimed at protecting the public from environmental and disease risk factors that lead to ill health. It is also involved in promoting safe practice and increasing consumer confidence in the products and services they access. This includes interventions to reduce the risks from environmental hazards and communicable diseases, and to manage outbreaks.

The Ministry provides ongoing purchasing and monitoring of border control and environmental health services on behalf of the Crown, exercises regulatory powers that minimise risks to the public, and supports the statutory and clinical leadership role of the Director of Public Health. The Ministry also gives advice to the health and disability system on regulatory functions. Key recipients of advice are individuals employed in the sector who are appointed as statutory officers by the Director-General and have powers to act in a regulatory capacity.

The Ministry undertakes a range of activities to coordinate public health protection and related regulatory functions across the country and between DHBs. The Ministry administered and provided advice on environmental health-related aspects of legislation as required. Six-monthly meetings were convened for DHB public health unit environmental health managers. Statutory officers employed by DHB public health units were provided with manuals, guidelines and training on implementing legislation and policy in areas of border health, drinking-water, hazardous substances, emergency management, legislation, environmental health surveillance and health protection.

The Ministry administered the Burial and Cremation Act 1964, including processing disinterment licences, applications for burials in special places, burial ground/cemetery applications, medical referee appointments and cremator applications. Health officials supported the Law Commission's review of the Burial and Cremation Act 1964.

The coordination of public health protection and related regulatory functions includes the appointment of statutory officers under the Health Act 1956, the Hazardous Substances and New Organisms Act 1996 and the Biosecurity Act 1993. The Director-General also appoints statutory officers under a range of other Acts, in particular the Smoke-free Environments Act 1990, the Tuberculosis Act 1948 and the Hazardous Substances and New Organisms Act 1996. All Directors of Area Mental Health Services appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 also met the criteria set by the Director-General of Health.

Statutory committees and regulatory authorities

The Ministry assists the Minister with the process of appointing members to statutory committees and regulatory authorities by sourcing candidates, compiling recommendations for appointment, conducting interviews with candidates, and preparing Cabinet documentation concerning appointments. The Ministry complies with the State Services Commission guidelines when assisting the Minister with appointments and provides the Minister with quality advice in a timely manner before members' terms expire.

Note A: The performance standard is based on the total number of appointments expected to be made in any given year, which is estimated in advance of that year. The actual number of appointments made will depend on a number of factors, including unexpected vacancies arising and the operational needs of the board. Expected appointments vary over a three-year cycle (55 in 2016/17; 42 in 2017/18; 103 in 2018/19).

Note B: The annual statutory committee satisfaction survey, covering the period July 2015 to June 2016, was conducted during July 2016. Of the 10 committees surveyed, nine responded. On a scale of 1 to 5 (1 being very dissatisfied and 5 being very satisfied), the measure of average satisfaction with the support provided by the Ministry to committees in the past 12 months was 3.9, a reduction from 4.1 in 2014/15.

Table 12: Financial performance for regulatory and enforcement services

Actual		Actual	Main	Supp.
30 June 2015		30 June 2016	Estimates	Estimates
\$000		\$000	30 June 2016	30 June 2016
			\$000	\$000
10,852	Revenue Crown	10,341	10,852	10,341
11,201	Third-party revenue	10,220	13,175	12,839
22,053	Total revenue	20,561	24,027	23,180
23,424	Total expenditure	22,739	24,027	23,180
-1,371	Net surplus/(deficit)	-2,178	0	0

Sector planning and performance

The Ministry works with DHBs to create accountability documents that outline what DHBs will deliver and what will help improve their performance. The Ministry also monitors progress throughout the year against targets (both service and financial) and works with DHBs to address issues that may be affecting their performance. The Ministry provides support for sector employment relations negotiations and pays particular attention to monitoring elective services. It is also responsible for DHB funding.

Table 13: Summary of output performance measures and standards for sector planning and performance

Actual 2014/15	Performance measure	Standard	Actual 2015/16
Planning and funding support systems			
Achieved	Planning and funding advice for the financial year is provided to Crown entities by 31 December	Achieved	Achieved
Achieved	The Ministry provides the Minister with advice on agreement of all DHB annual plans by 30 June	Achieved	Achieved
Performance monitoring			
100%	The percentage of monitoring feedback reports about performance supplied to DHBs within agreed timeframes	90%	100%
100%	The percentage of all letters to DHBs, with health target performance tables and supporting information, provided to the Minister within 5 working days of the date for publication	100%	100%
50%	The percentage of quarterly and monthly monitoring reports about DHBs provided to the Minister within agreed timeframes	100%	55% (see Note A)
100%	The percentage of quarterly and monthly monitoring reports about Crown entities (excluding DHBs) provided to the Minister within agreed timeframes	100%	100%
Emergency response			
Within 2 hours	Percentage of emergency responses to national emergencies is available within 2 hours	100%	100%
5 people	The number of people who annually receive 2 training/exercise sessions on National Health Coordination Centre (NHCC) activation and response	30 people	13 people (see Note B)
Achieved	Quarterly regional or national health sector emergency planner meetings held in each region	Achieved	Achieved
Governance			
100%	The percentage of appointments to DHBs and other health Crown entity boards where advice is presented to the Minister prior to the current appointee's term expiring	100%	100%
7	The number of appointments to DHBs and other health Crown entity boards	15	40 (see Note C)

Planning and funding support systems

Advice to assist Crown entities to plan for the upcoming financial year needs to be provided by the end of the calendar year. The 2015/16 planning package was distributed to DHBs on 11 December 2015.

By working closely and collaboratively with DHBs, the Ministry expects to facilitate agreements on plans by 30 June of each year. The timeliness target for agreements between DHBs and the Ministry is a proxy measure of the quality of the activities undertaken by the Ministry in support of this aim, such as facilitation, feedback and advice on draft plans. The Ministry is only an advisor in the process, since ministers and DHBs sign off the plans.

Performance monitoring

The Ministry uses a number of performance indicators to set expectations and monitor performance to ensure DHBs appropriately work towards New Zealand Health Strategy priorities and achieve stated government priorities for performance improvement and health outcomes. A vital part of the reporting process is the feedback (assessments) the Ministry gives to DHBs on each of these measures, particularly when improvement on performance is necessary and/or remedial actions are required. Feedback must be timely so that DHBs can introduce modifications to improve performance in the relevant period.

DHBs are accountable for achieving the health targets, and results are published in national and local newspapers and online (these results rank DHBs against each other). Early advice on target performance allows DHBs to manage the impact of the publication of the results. Draft health target letters were sent to the Minister within five working days of the publication of results. The Minister then sent health target performance letters to each DHB. The Ministry produces and circulates the tables used to publish health target results to DHBs quarterly. This is a significant way in which performance of the sector is communicated to the public.

The Ministry is responsible for the funding, monitoring and planning of DHBs and other health Crown entities. As such, it reports to the Minister periodically in the following performance areas:

- DHB financial performance: a monthly report highlighting where a DHB reports a significant variance against a plan, enabling areas of financial pressure and risk to be identified, as well as best practice within the DHB sector
- DHB performance on health targets: a quarterly report containing detailed results and remedial actions
- overall quarterly report on DHB performance, including non-financial information, information on health target performance and financial information: this provides the Minister with an integrated high-level view of DHB performance
- health Crown entity performance: a quarterly report describing major achievements, performance against planned outputs, financial performance and governance commentary.

Note A: The Ministry's monitoring reports form the basis for the Ministry's advice to DHBs and health Crown entities, as well as to the Minister. DHB monitoring reports to the Minister did not achieve the target set. The delay to the sector financial report was due to the need to seek additional supporting variance analysis and the time needed to prepare and review the reports.

Emergency response

The Ministry maintains the capability and capacity to lead and coordinate a national health response to an emergency. In addition, it has prepared plans to continue functioning during and after an emergency, in accordance with sections 58 and 59 of the Civil Defence Emergency Management Act 2002 (which require all government departments to prepare such plans).

The Ministry has the capability to activate the National Health Coordination Centre (NHCC) within two hours of any emergency event that requires national health coordination. Primary and alternative sites for the NHCC have been identified at Ministry offices. The emergency management information system also allows for the NHCC to be set up at an alternative location with internet access, if required.

The capability to activate an emergency response within two hours of notification has been maintained throughout 2015/16. While there have been no national emergencies declared during this period, the Ministry has responded to a wide range of hazards and threats managed within the national security system. This has seen an effective collaborative response across teams in the Ministry, including the Emergency Management Team, Office of the Director of Public Health, Communicable Disease Team, the Environmental Health Team, and Communications.

Note B: Over the last financial year the Ministry has had to concentrate on supporting existing trained staff from across the Ministry to respond effectively to a range of National Security System events. Key response activity has included response to the hepatitis A outbreak from contaminated frozen berries, monitoring and provision of national guidance relating to the WHO Public Health Emergency of International Concern for the Zika virus, support to DHBs for local events, and response to cyclones in the South Pacific. These events have provided significant operational experience for trained staff.

In addition, since 4 August 2016 the Ministry has facilitated weekly briefings for the Emergency Management Team, the Public Health Group, Communications and other internal and external stakeholders to coordinate readiness and response activity for international and domestic events. Attendance at these briefings averages 10 staff, and over 150 hours of cross-Ministry coordination and readiness work has been delivered against this. The weekly briefings have catalysed cross-Ministry and business unit collaborative work.

Due to the change in the model for training and education of response staff, this measure has been removed for 2016/17.

Governance

The Minister, in consultation with Cabinet and Caucus, appoints suitable candidates to DHB and other health Crown entity boards. The Ministry assists the Minister with the appointments process by sourcing candidates, compiling recommendations for appointment, conducting interviews with candidates, and preparing Cabinet documentation concerning appointments. The Ministry complies with the State Services Commission guidelines when assisting the Minister with appointments and provides the Minister with quality advice in a timely manner before members' terms expire.

Note C: The performance standard is based on the total number of appointments expected to be made in any given year, which is estimated in advance of that year. The actual number of appointments made will depend on a number of factors, including unexpected vacancies arising and the operational needs of the board. The target has been adjusted to 15 for 2015/16 to align with the expected number of appointments.

Table 14: Financial performance for sector planning and performance

Actual		Actual	Main	Supp.
30/06/2015		30/06/2016	Estimates	Estimates
\$000		\$000	30/06/2016	30/06/2016
			\$000	\$000
47,641	Revenue Crown	46,847	47,678	46,847
300	Third-party revenue	466	360	694
47,941	Total revenue	47,313	48,038	47,541
49,439	Total expenditure	47,050	48,038	47,541
-1,498	Net surplus/(deficit)	263	0	0

Policy advice and ministerial servicing

The policy advice category is intended to provide Ministers with policy advice that appropriately informs them on issues affecting the health portfolio, Government priorities, and when otherwise appropriate. The ministerial servicing category is intended to provide Ministers with support so that they can discharge their portfolio responsibilities.

Table 15: Summary of output performance measures and standards for policy advice

Actual 2014/15	Performance measure	Standard	Actual 2015/16
	How performance will be assessed for the multi-class appropriation as a whole		
80%	The average score for Minister's overall satisfaction with written and verbal advice (as assessed on a four-monthly annual basis)	80%	83.6%
	Ministerial servicing		
	This category is intended to achieve the following: Ministers are provided with support so that they can discharge their portfolio responsibilities		
96.8%	The percentage of responses provided to the Minister within agreed timeframes; for written parliamentary questions and Ministerial letters	96%	97.6%
New	The percentage of responses provided to the Minister within agreed timeframes; for requested briefings	96%	93.6%
98%	The percentage of Ministerial letters that required no revision	98%	98.9%
92%	The percentage of responses to Official Information Act requests, provided to the Minister within agreed timeframes (for requests made to the Minister) or to the requestor within the statutory timeframe, including where extended in line with the Act (for requests made to the Ministry)	95%	88.9% (see Note A)
	Policy advice		
	This category is intended to achieve the following: Ministers are provided with policy advice that appropriately informs them about issues affecting the health portfolio, Government priorities, and when otherwise appropriate		
7.43	The average score attained by written policy advice as assessed by an external reviewer	>7 out of 10	7.1
\$167.06	Total policy function cost per output hour	\$165 to \$175	\$178.98

Policy advice

The Ministry surveys the Minister on the degree to which the Ministry's verbal and written advice met his expectations, using a five-point scoring system, with 5 being the highest score. Generally, the Ministry undertakes the survey at four-monthly.

As part of the Ministry's commitment to improving its performance, each year it asks an independent assessor to review the quality of its written advice to Ministers. Papers were randomly selected for this purpose. In the latest review report, the independent assessor noted:

The sample indicates that the upward trend of quality that we have seen over the past few years has hit a speed bump. The average score slipped to 7.1 this year from 7.5 last year.

This should not be a cause of huge concern – there are still plenty of positive signs and we know you have the capability to perform – but it is a useful reminder that you need to keep innovating and thinking carefully about what good quality advice looks like.

Ministerial servicing

The Ministry provides a wide range of advice and services to ministers. During 2015/16 the Ministry responded to 3963 pieces of ministerial correspondence (made up of direct replies, written parliamentary questions and ministerial letters). Of the 646 requested briefings drafted by the Ministry, 540 were completed on time.

Official Information Act (OIA) requests

Note A: During 2015/16 the Ministry responded to 1081 OIA requests, meeting the agreed timeframe for 962 of those. The Ministry was tracking against target until the last three months of the year, when there was a noticeably higher level of overdue OIA responses. A significant percentage of the overdue OIAs were only overdue by one or two days.

Table 16: Financial performance for policy advice

Actual		Actual	Main	Supp.
30/06/2015		30/06/2016	Estimates	Estimates
\$000		\$000	30/06/2016	30/06/2016
			\$000	\$000
21,188	Revenue Crown	20,768	21,188	20,768
0	Third-party revenue	0	0	0
21,188	Total revenue	20,768	21,188	20,768
20,878	Total expenditure	20,705	21,188	20,768
310	Net surplus	63	0	0

Statement of responsibility

I am responsible, as Director-General of Health and Chief Executive of the Ministry of Health (the Ministry), for:

- the preparation of the Ministry's financial statements, and statements of expenses and capital expenditure, and for the judgements expressed in them
- having in place a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting
- ensuring that end-of-year performance information on each appropriation administered by the Ministry is provided in accordance with sections 19A to 19C of the Public Finance Act 1989, whether or not that information is included in this annual report
- the accuracy of any end-of-year performance information prepared by the Ministry, whether or not that information is included in the annual report.

In my opinion:

- the financial statements fairly reflect the financial position of the Ministry as at 30 June 2016 and its operations for the year ended on that date
- the forecast financial statements fairly reflect the forecast financial position of the Ministry as at 30 June 2017 and its operations for the year ending on that date.



Chai Chuah
Director-General of Health
30 September 2016



Stephen O'Keefe
Chief Financial Officer
30 September 2016

Independent auditor's report

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Independent Auditor's Report

To the readers of Ministry of Health's annual report for the year ended 30 June 2016

The Auditor-General is the auditor of Ministry of Health (the Ministry). The Auditor-General has appointed me, Kelly Rushton, using the staff and resources of Audit New Zealand, to carry out the audit on her behalf of:

- the financial statements of the Ministry on pages 82 to 104, that comprise the statement of financial position, statement of commitments, statement of contingent liabilities and contingent assets as at 30 June 2016, the statement of comprehensive revenue and expense, statement of movements in equity, and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information;
- the performance information prepared by the Ministry for the year ended 30 June 2016 on pages 12 to 20 and 38 to 71;
- the statement of budgeted and actual expenses and capital expenditure against appropriation of the Ministry for the year ended 30 June 2016 on pages 79 to 81; and
- the schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 105 to 114 that comprise:
 - the schedules of assets, liabilities, commitments, contingent liabilities and contingent assets as at 30 June 2016;
 - the schedules of expenses, revenue and capital receipts for the year ended 30 June 2016;

- the statement of trust monies for the year ended 30 June 2016;
- statement of expenses and capital expenditure against appropriations for the year ended 30 June 2016;
- Problem Gambling levy report for the year ended 30 June 2016;
- statement of unappropriated expenses and capital expenditure for the year ended 30 June 2016; and
- the notes to the schedules that include accounting policies and other explanatory information.

Opinion

In our opinion:

- the financial statements of the Ministry on pages 82 to 104:
 - present fairly, in all material respects:
 - its financial position as at 30 June 2016;
 - its financial performance and cash flows for the year ended on that date; and
 - comply with generally accepted accounting practice in New Zealand and have been prepared in accordance with the Public Benefit Entity Reporting Standards.

Qualified opinion on the performance information because of limited control on information from third-party health providers

Some significant performance measures of the Ministry of Health, (including the national health targets relating to increased immunisation, better help for smokers to quit, and more heart and diabetes checks) rely on information from third-party health providers, such as primary health organisations. The Ministry of Health's control over much of this information for the current year and the previous year is limited, and there are no practical audit procedures to determine the effect of this limited control.

In our opinion, except for the effect of the matter described above, the performance information of the Ministry on pages 12 to 20 and 38 to 71:

- presents fairly, in all material respects, for the year ended 30 June 2016:
 - what has been achieved with the appropriation; and
 - the actual expenses or capital expenditure incurred compared with the appropriated or forecast expenses or capital expenditure.
- complies with generally accepted accounting practice in New Zealand.

Opinion on the statements of expenses and capital expenditure

The statements of budgeted and actual expenses and capital expenditure against appropriations of the Ministry on pages 79 to 81 are presented fairly, in all material respects, in accordance with the requirements of section 45A of the Public Finance Act 1989.

Opinion on the schedules of non-departmental activities

The schedules of non-departmental activities which are managed by the Ministry on behalf of the Crown on pages 105 to 114 present fairly, in all material respects, in accordance with the Treasury Instructions:

- the schedules of assets, liabilities, commitments, contingent liabilities and contingent assets as at 30 June 2016;
- the schedules of expenses, revenue and capital receipts for the year ended 30 June 2016;
- the statement of trust monies for the year ended 30 June 2016
- statement of expenses and capital expenditure against appropriations for the year ended 30 June 2016;
- Problem Gambling levy report for the year ended 30 June 2016;
- statement of unappropriated expenses and capital expenditure for the year ended 30 June 2016; and
- the notes to the schedules that include accounting policies and other explanatory information.

Our audit was completed on 30 September 2016. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Director-General of Health and our responsibilities, and we explain our independence.

Basis of opinion

We carried out our audit in accordance with the Auditor-General's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the information we audited is free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the information we audited. We were unable to determine whether there are material misstatements in the performance information because the scope of our audit work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the information we audited. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the information we audited, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the Ministry's preparation of the information we audited in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Ministry's internal control.

An audit also involves evaluating:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Director-General of Health;

- the appropriateness of the reported performance information within the Ministry’s framework for reporting performance;
- the adequacy of the disclosures in the information we audited; and
- the overall presentation of the information we audited.

We did not examine every transaction, nor do we guarantee complete accuracy of the information we audited. Also, we did not evaluate the security and controls over the electronic publication of the information we audited.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our unmodified audit opinions on the Ministry’s financial statements, statements of expenses and capital expenditure and schedules of non–departmental activities, and our qualified audit opinion on the Ministry’s performance information.

Responsibilities of the Director–General of Health

The Director–General of Health is responsible for preparing:

- financial statements that present fairly the Ministry’s financial position, financial performance, and its cash flows, and that comply with generally accepted accounting practice in New Zealand;
- performance information that presents fairly what has been achieved with each appropriation, the expenditure incurred as compared with expenditure expected to be incurred, and that complies with generally accepted accounting practice in New Zealand;
- statements of expenses and capital expenditure of the Ministry, that are presented fairly, in accordance with the requirements of the Public Finance Act 1989; and
- schedules of non–departmental activities, in accordance with the Treasury Instructions, that present fairly those activities managed by the Ministry on behalf of the Crown.

The Director–General of Health’s responsibilities arise from the Public Finance Act 1989.

The Director-General of Health is responsible for such internal control as is determined is necessary to ensure that the annual report is free from material misstatement, whether due to fraud or error. The Director-General of Health is also responsible for the publication of the annual report, whether in printed or electronic form.

Responsibilities of the Auditor

We are responsible for expressing an independent opinion on the information we are required to audit, and reporting that opinion to you based on our audit. Our responsibility arises from the Public Audit Act 2001.

Independence

When carrying out the audit, we followed the independence requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Ministry.



Kelly Rushton
Audit New Zealand
On behalf of the Auditor-General
Wellington, New Zealand

Section 2:

Financial statements

Statement of budgeted and actual expenses and capital expenditure against appropriations for the year ended 30 June 2016

Actual expenditure 2015 \$000	Appropriation title	Actual expenditure 2016 \$000	Main estimates 2016 \$000	Voted [^] appropriation 2016 \$000	Actual expenditure as a % of total Vote \$000	Location of end-of-year performance information
Vote: Health						
Departmental output expenses						
31,252	Managing the purchase of services	31,790	30,807	32,626	0.21%	
23,424	Regulatory and enforcement services	22,739	24,027	23,180	0.15%	Ministry of Health
49,439	Sector planning and performance	47,050	48,038	47,191	0.30%	Annual Report
50,338	Health Sector Information Systems	50,110	50,201	50,661	0.32%	
17,908	Payment Services	17,907	18,171	18,027	0.12%	
172,361	Total departmental output expenses	169,596	171,244	171,685	1.10%	
Multi-category expense and capital expenditure						
Policy advice and Ministerial servicing MCA						
4,661	Ministerial servicing	4,592	4,747	4,620	0.03%	Ministry of Health
16,164	Policy advice	16,113	16,441	16,148	0.11%	Annual Report
20,825	Total multi-category expense and capital expenditure	20,705	21,188	20,768	0.14%	
193,186	Total Departmental Output appropriations	190,301	192,432	192,453	1.24%	
Departmental capital expenditure						
12,753	Ministry of Health – permanent legislative authority	11,535	–	14,209	0.08%	Ministry of Health Annual Report
Departmental capital injections						
1,517	Ministry of Health – capital injection	–	315	315	0.00%	Ministry of Health Annual Report

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

The accompanying notes on pages 87 to 104 and 111 to 114 are an integral part of these financial statements and schedules.

Actual expenditure 2015 \$000	Appropriation title		Actual expenditure 2016 \$000	Main estimates 2016 \$000	Voted [^] appropriation 2016 \$000	Actual expenditure as a % of total Vote \$000	Location of end-of-year performance information
Non-departmental output expenses							
Health and disability support services for District Health Boards (DHBs):							
487,868	Northland DHB		511,786	509,308	511,786	3.35%	
1,311,848	Waitemata DHB		1,349,320	1,342,072	1,349,321	8.82%	
1,092,298	Auckland DHB		1,118,297	1,115,555	1,118,297	7.31%	
1,246,364	Counties Manukau DHB		1,274,349	1,268,476	1,274,349	8.33%	
1,002,406	Waikato DHB		1,042,740	1,040,100	1,042,741	6.82%	
278,253	Lakes DHB		284,778	283,482	284,778	1.86%	
614,392	Bay of Plenty DHB		638,060	633,648	638,061	4.17%	
144,332	Tairāwhiti DHB		147,136	146,813	147,136	0.96%	
304,188	Taranaki DHB		318,643	317,712	318,644	2.08%	
435,492	Hawke's Bay DHB		457,148	457,128	461,348	2.99%	
202,295	Whanganui DHB		206,464	205,636	206,465	1.35%	DHBs Annual
458,021	MidCentral DHB		467,256	465,870	467,257	3.06%	Reports
357,834	Hutt Valley DHB		365,331	363,557	365,331	2.39%	
678,807	Capital and Coast DHB		690,915	689,554	690,915	4.52%	
122,511	Wairarapa DHB		128,179	127,817	128,179	0.84%	
378,204	Nelson-Marlborough DHB		394,740	393,161	394,740	2.58%	
119,604	West Coast DHB		121,928	121,511	121,929	0.80%	
1,268,439	Canterbury DHB		1,314,527	1,281,426	1,317,045	8.60%	
164,568	South Canterbury DHB		167,795	167,378	167,795	1.10%	
776,461	Southern DHB		791,729	789,623	791,730	5.18%	
11,444,185	Total health and disability support services for District Health Boards		11,791,121	11,719,827	11,797,847	77.11%	
1,126,061	National disability support services	2.1	1,167,483	1,158,113	1,167,968	7.64%	
396,571	Public health services purchasing	2.2	372,112	427,491	376,602	2.43%	
82,538	National child health services		83,559	87,048	85,249	0.55%	
289,972	National elective services	2.3	323,180	316,512	324,367	2.11%	
97,105	National emergency services		95,540	96,440	95,559	0.62%	
4,195	National Māori health services	2.4	4,066	7,308	4,517	0.03%	
143,848	National maternity services		144,589	146,767	144,657	0.95%	
45,626	National mental health services	2.5	53,114	55,797	53,482	0.35%	
21,171	National contracted services – other		24,518	45,378	25,820	0.16%	Vote Health
242	National advisory and support services		–	260	–	0.00%	Annual Report
27,583	Monitoring and protecting health and disability consumer interests		27,510	27,096	27,596	0.18%	
15,735	Problem gambling services		18,205	17,130	20,630	0.12%	
176,560	Health workforce training/development		176,252	174,250	176,302	1.15%	
154,935	Primary health care strategy	2.6	179,615	172,130	179,974	1.17%	
84,748	National Personal Health Services		105,563	77,933	107,428	0.69%	
13,851	National Health Information Systems		10,534	14,887	12,046	0.07%	
2,680,741	Total non-departmental output expenses (other)		2,785,840	2,824,540	2,802,197	18.22%	
14,124,926	Total non-departmental output expenses		14,576,961	14,544,367	14,600,044	95.33%	

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

The accompanying notes on pages 87 to 104 and 111 to 114 are an integral part of these financial statements and schedules.

Actual expenditure 2015 \$000	Appropriation title		Actual expenditure 2016 \$000	Main estimates 2016 \$000	Voted [^] appropriation 2016 \$000	Actual expenditure as a % of total Vote \$000	Location of end-of-year performance information
Non-departmental other expenses							
1,480	International health organisations		1,639	2,030	1,650	0.01%	
607	Legal expenses		959	1,028	1,028	0.01%	Exempt
24,393	Provider development		22,709	25,414	22,975	0.15%	
26,480	Total non-departmental other expenses		25,307	28,472	25,653	0.17%	
Non-departmental capital expenditure							
13,500	Deficit support for DHBs	2.7	14,000	55,000	38,624	0.09%	DHB Annual Reports
15,880	Equity for capital projects for DHBs and the NZ Blood Service	2.8	41,030	304,000	71,949	0.27%	
109,750	Health sector projects	2.9	162,418	390,000	240,716	1.06%	
50,700	Loans for capital projects	2.10	–	74,000	23,345	0.00%	Vote Health
–	Refinance of DHB private debt		50,000	50,000	50,000	0.33%	Annual Report
476,036	Refinance of Crown Loans	2.11	207,520	200,100	210,824	1.36%	
10,518	Residential care loans		10,653	15,000	15,000	0.07%	
676,384	Total non-departmental capital contributions to other persons or organisations		485,621	1,088,100	650,458	3.18%	
14,827,790	Total non-departmental appropriations		15,087,889	15,660,939	15,276,155	98.68%	
15,035,246	TOTAL VOTE HEALTH		15,289,725	15,853,686	15,483,132	100.00%	

[^] These amounts include adjustments made in the Supplementary Estimates and under Section 26A of the Public Finance Act 1989.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

The accompanying notes on pages 87 to 104 and 111 to 114 are an integral part of these financial statements and schedules.

Statement of comprehensive revenue and expense for the year ended 30 June 2016

The Statement of Comprehensive Revenue and Expenses details the revenue and expenses relating to all outputs (goods and services) produced by the Ministry during the financial year ended 30 June 2016. Total expenses equals total departmental output expenditure, Multi-Category Expenses and appropriations in the Statement of Departmental Expenses and Capital Expenditure against Appropriations on page 79.

Actual 2015 \$000	Note	Actual 2016 \$000	Unaudited budget 2016 \$000	Unaudited forecast 2017 \$000
Revenue				
180,598	Revenue Crown	178,920	178,275	182,661
11,983	Revenue other	10,688	14,157	13,016
192,581	Total operating revenue	189,608	192,432	195,677
Expenses				
113,049	Personnel costs	113,654	113,697	114,015
9,965	Depreciation and amortisation expense	11,190	10,397	10,000
2,579	Capital charge	2,576	2,524	2,587
67,541	Other operating expenses	62,883	65,814	69,075
52	Net (gains)/losses on sale/disposal of property, plant and equipment	(2)		-
193,186	Total expenses	190,301	192,432	195,677
(605)	Net surplus/(deficit)	(693)	-	-
Other comprehensive revenue and expense				
(500)	Gain/(Loss) on property revaluations	550	-	-
(1105)	Total comprehensive revenue and expense	(143)	-	-

Explanations of significant variances against budget are detailed in note 18.

The notes set out on pages 87 to 104 form part of, and are to be read in conjunction with, these financial statements.

Statement of movements in equity for the year ended 30 June 2016

Actual 2015 \$000	Note	Actual 2016 \$000	Unaudited budget 2016 \$000	Unaudited forecast 2017 \$000
34,647	Balance at 1 July	35,292	35,292	35,149
(1,105)	Total comprehensive revenue and expense	(143)	–	–
233	Memorandum account write off	–	–	–
	Owner transactions			
1,517	Capital injection	–	315	–
–	Return of operating surplus to the Crown	9	–	–
35,292	Balance at 30 June	34,541	35,607	35,149

The notes set out on pages 87 to 104 form part of, and are to be read in conjunction with, these financial statements.

Statement of financial position as at 30 June 2016

Actual		Note	Actual	Unaudited budget	Unaudited forecast
2015			2016	2016	2017
\$000			\$000	\$000	\$000
	Equity				
30,159	Taxpayer's funds	12	30,159	30,474	30,767
2,040	Land and building revaluation reserve	12	2,590	2,040	2,590
3,093	Memorandum accounts	12	1,792	3,093	1,792
35,292	Total equity		34,541	35,607	35,149
	Represented by:				
	Assets				
	Current assets				
207	Cash and cash equivalents		6,423	2,000	9,000
1,433	Debtors and other receivables		947	9,835	1,000
10,700	Crown Debtors		1,458	–	3,007
2,617	Prepayments		2,153	2,601	2,894
14,957	Total current assets		10,981	14,436	15,901
	Non-current assets				
14,508	Property, plant and equipment	6	14,886	14,076	6,018
35,325	Intangible assets	7	34,239	36,860	37,239
49,833	Total non-current assets		49,125	50,936	43,257
64,790	Total assets		60,106	65,372	59,158
	Liabilities				
	Current liabilities				
15,365	Creditors and other payables	8	11,731	14,361	14,041
–	Operating surplus to be returned to the Crown	9	608	–	–
1,132	Provisions	10	3,691	1,451	500
8,840	Employee entitlements	11	8,162	8,977	8,000
25,337	Total current liabilities		24,192	24,789	22,541
	Non-current liabilities				
2,750	Provisions	10	30	3,522	30
1,411	Employee entitlements	11	1,343	1,454	1,438
4,161	Total non-current liabilities		1,373	4,976	1,468
29,498	Total liabilities		25,565	29,765	24,009
35,292	Net assets		34,541	35,607	35,149

Explanations of significant variances against budget are detailed in note 18.

The notes set out on pages 87 to 104 form part of, and are to be read in conjunction with, these financial statements.

Statement of cash flows for the year ended 30 June 2016

Actual		Note	Actual	Unaudited	Unaudited
2015			2016	budget	forecast
\$000			\$000	2016	2017
				\$000	\$000
Cash flows from operating activities					
Cash was provided from:					
Supply of outputs to:					
180,373	Receipts from Crown Revenue		188,162	180,774	172,664
12,271	Receipts from other revenue		10,884	14,485	13,016
(67,121)	Payments to suppliers		(66,622)	(73,407)	(69,347)
(111,865)	Payments to employees		(113,281)	(106,094)	(108,413)
(2,579)	Payments for capital charge		(2,576)	(2,524)	(2,587)
214	Net GST received/(paid)		(391)	(256)	(256)
11,293	Net cash provided from operating activities	13	16,176	12,978	5,077
Revenue in advance					
Cash flows from investing activities					
41	Receipts from sale of property, plant and equipment		1,575	–	12,000
(7,463)	Purchase of property, plant and equipment		(5,188)	(3,500)	(8,500)
(5,289)	Purchase of intangible assets		(6,347)	(8,000)	(6,000)
(12,711)	Net cash outflow from investing activities		(9,960)	(11,500)	(2,500)
Cash flows from financing activities					
1,517	Capital injections		–	315	–
(2,248)	Repayment of surplus to the Crown		–	–	–
(731)	Net cash flows from financing activities		–	315	–
(2,149)	Net increase/(decrease) in cash and cash equivalents held		6,216	1,793	2,577
2,356	Add cash and cash equivalents at the beginning of the year		207	207	6,423
207	Cash and cash equivalents at the end of the year		6,423	2,000	9,000

The notes set out on pages 87 to 104 form part of, and are to be read in conjunction with, these financial statements.

Statement of commitments as at 30 June 2016

Actual		Actual
2015 \$000		2016 \$000
	Capital commitments	
–	Property, plant and equipment	–
1,987	Intangible assets	368
–	Other capital commitments	–
1,987	Total capital commitments	368
	Non-cancellable operating lease commitments	
6,801	Not later than one year	7,981
28,762	Later than one year and not later than five years	29,774
55,769	Later than five years	82,439
91,332	Total non-cancellable operating lease commitments	120,194
93,319	Total commitments	120,562

The Ministry has medium- to long-term leases on its premises in Auckland, Christchurch, Dunedin, Hamilton, Whanganui and Wellington. The annual lease payments are subject to regular reviews, ranging from one year to four years. The amounts disclosed above as future commitments are based on current rental rates.

Statement of contingent liabilities and contingent assets as at 30 June 2016

The Ministry had no contingent liabilities as at 30 June 2016 (2015: Nil).

The Ministry had no contingent assets as at 30 June 2016 (2015: Nil).

Statement of unappropriated departmental expenditure and capital expenditure for the year ended 30 June 2016

There was no unappropriated departmental expenditure for the year ended 30 June 2016 (2015: Nil).

The notes set out on pages 87 to 104 form part of, and are to be read in conjunction with, these financial statements.

Notes to the financial statements for the year ended 30 June 2016

Note 1: Statement of accounting policies for the year ended 30 June 2016

Reporting entity

The Ministry of Health (the Ministry) is a government department as defined by section 2 of the Public Finance Act 1989. The relevant legislation governing the Ministry's operations includes the Public Finance Act 1989 and New Zealand Public Health and Disability Act 2000. The Ministry's ultimate parent is the New Zealand Crown.

The primary objective of the Ministry is to act as the Government's agent to fund, administer and monitor the delivery of health services to New Zealanders, rather than to make a financial return. Accordingly, the Ministry has designated itself as a public benefit entity (PBE) for financial reporting purposes.

The Ministry's financial statements are for the year ended 30 June 2016. The financial statements were authorised for issue by the Director-General of Health on 30 September 2016.

In addition, the Ministry has reported the activities and trust monies that it administers on behalf of the Crown.

The Departmental Financial Statements and the financial information reported in the Non-departmental Schedules are consolidated into the Financial Statements of the Government and therefore readers of these schedules should also refer to the Financial Statements of the Government for the year ended 30 June 2016.

Basis of preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

Statement of compliance

The financial statements of the Ministry have been prepared in accordance with the requirements of the Public Finance Act 1989, which include the requirement to comply with New Zealand generally accepted accounting practice (NZ GAAP), and Treasury Instructions. Measurement and recognition rules applied in the preparation of the Non-departmental Supplementary Financial Schedules are consistent with NZ GAAP and Crown accounting policies and are detailed in the Financial Statements of the Government. These Financial Statements have been prepared in accordance with Tier 1 NZ PBE accounting standards.

Measurement base

The Financial Statements have been prepared on an historical cost basis, modified by the revaluation of certain assets and liabilities as described in this statement of accounting policies.

Functional and presentation currency

The financial statements are presented in New Zealand dollars being the functional currency of the Ministry. Unless stated otherwise, all values are rounded to the nearest thousand dollars (\$000).

Budget and forecast figures

The budget figures (Main Estimates) are the original figures for the 2016 financial year as presented in the 2015 Budget Economic and Fiscal Update (BEFU) and were published in the 2014/15 annual report as the 2016 Forecast.

Forecast Financial Statements have been prepared in accordance with the accounting policies expected to be used in the future for reporting historical general purpose financial statements. These Forecast Financial Statements have been prepared in accordance with NZ PBE IPSAS.

The 2017 forecast figures are for the year ending 30 June 2017 and are based on the BEFU and have been prepared on the basis of assumptions as to future events that the Ministry reasonably expects to occur, associated with the actions it reasonably expects to take. They have been compiled on the basis of existing government policies and ministerial expectations at the date that the information was prepared.

Judgements and estimations

The preparation of financial statements is in conformity with NZ GAAP and requires judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the reporting period in which the revision is made and in any future periods that will be affected by those revisions.

Significant assumptions

The main assumptions were as follows:

- The Ministry's activities and output expectations will remain substantially the same as the previous year focusing on the Government's priorities.
- Personnel costs were based on current wages and salary costs, adjusted for anticipated remuneration changes.
- Operating costs were based on historical experience and other factors that are believed to be reasonable in the circumstances and are the Ministry's best estimate of future costs that will be incurred.

The forecast financial statements were approved for issue by the Chief Executive on 25 April 2016. The Chief Executive is responsible for the forecast financial statements, including the appropriateness of the assumptions underlying them and all other required disclosures.

Variations to forecast

The actual financial results for the forecast period covered are likely to vary from the information presented in these forecasts. Factors that may lead to a material difference between information in these forecast financial information statements and the actual reported results include:

- changes to the budget through initiatives approved by Cabinet
- technical adjustments to the budget including transfers between financial years
- the timing of expenditure relating to significant programmes and projects.

Any changes to budgets during 2016–17 will be incorporated into *The Supplementary Estimates of Appropriations* for the year ending 30 June 2017.

Revenue

The Ministry derives revenue through the provision of outputs to the Crown and for services to third parties. Such revenue is recognised at fair value of consideration received.

Revenue from the Crown is measured based on the Ministry's funding entitlement for the reporting period. The funding entitlement is established by Parliament when it passes the Appropriation Acts for the financial year. The amount of revenue recognised takes into account any amendments to appropriations approved in the Appropriation (Supplementary Estimates) Act for the year and certain other unconditional funding adjustments formally approved prior to balance date.

There are no conditions attached to the funding from the Crown. However, the Ministry can incur expenses only within the scope and limits of its appropriations.

The fair value of Revenue Crown has been determined to be equivalent to the funding entitlement.

Other revenue from the supply of services is recognised by reference to the stage of completion of the transaction at balance date and only to the extent that the outcome of the transaction can be estimated reliably.

Cost allocation

Direct costs are those costs directly attributed to an output. Indirect costs are those costs that cannot be identified in an economically feasible manner with any one specific output.

Direct costs are charged directly to outputs while indirect costs are allocated to outputs based on the level of activity associated with relevant cost drivers.

Depreciation is primarily charged as direct costs to outputs on the basis of asset utilisation: the remainder is charged as indirect costs.

There have been no changes in the cost allocation policy since the date of the last audited financial statements.

Taxation

As a government department, the Ministry is exempt from the payment of income tax in terms of the Income Tax Act 2007. Accordingly, no charge for income tax is recognised.

Equity

Equity is the Crown's net investment in the Ministry and is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified as taxpayers' funds, property revaluation reserves and memorandum accounts.

Property revaluation reserves

These reserves relate to the revaluation of land and buildings to fair value.

Memorandum accounts

Memorandum accounts reflect the cumulative surplus/(deficit) on those departmental services provided that are intended to be fully cost recovered from third parties through fees, levies or charges. The balance of each memorandum account is expected to trend toward zero over time.

Cash and cash equivalents

Comprise funds in current accounts with Westpac New Zealand Limited, a registered bank.

Property plant and equipment

Items of property, plant and equipment are initially recorded at cost. Where an asset is acquired for nil or nominal consideration the asset will be recognised initially at fair value, where fair value can be reliably determined. The fair value of the asset received, less costs incurred to acquire the asset, is recognised as revenue in the Statement of Comprehensive Revenue and Expense.

All individual assets or groups of assets are capitalised if their historical cost is \$4,000 or greater.

Land is recorded at fair value less impairment losses. Buildings are recorded at fair value less impairment losses and less depreciation accumulated since the assets were last revalued. Valuations are based on either valuation undertaken in accordance with standards issued by the New Zealand Property Institute if available, or valuation conducted in accordance with the Rating Valuation Act 1998 that has been confirmed as appropriate by an independent valuer.

Revaluations are carried out for the Ministry's land and buildings to reflect the service potential or economic benefit obtained through control of the asset. Revaluation is based on the fair value of the asset, with changes reported by class of asset.

Accumulated depreciation at revaluation date may be either restated proportionately or eliminated against the gross carrying amount so that the carrying amount after revaluation equals the revalued amount. The elimination approach is applied unless otherwise indicated.

All other asset classes are initially carried at depreciated historical cost, with a review of the carrying values of revalued items performed at each balance date to determine whether any material adjustment is required.

Classes of property, plant and equipment subject to fair value review are revalued at least every three years or sooner where indicators suggest the carrying amount differs materially to fair value. Unrealised gains and losses arising from changes in the value of property, plant and equipment are recognised as at each balance date. To the extent that a gain reverses a loss

previously charged to the Statement of Comprehensive Revenue and Expense for the asset class, the gain is credited to the Statement of Comprehensive Revenue and Expense; otherwise gains are credited to the asset revaluation reserve for that class of asset. To the extent that there is a balance in the asset revaluation reserve for the asset class, any loss on revaluation is debited to the reserve to the extent that a balance remains in such reserve. All other losses on property, plant and equipment are reported in the Statement of Comprehensive Revenue and Expense.

For each property, plant and equipment asset, project borrowing costs incurred during the period required to complete and prepare the asset for its intended use are expensed.

Depreciation is charged on a straight-line basis at rates calculated to allocate the cost or valuation of an item of property, plant and equipment, less any estimated residual value, over its estimated useful life. Typically, the estimated useful lives of different classes of property, plant and equipment are as follows:

	Useful life	Depreciation rate
Buildings	40 years	2.5%
Motor vehicles	5 years	20%
Furniture and fittings	5–10 years	10–20%
Machinery	5 years	20%
Leasehold improvements	5–10 years	10–20%
IT equipment	3–5 years	20–33.3%

Additions

The cost of an item of property, plant and equipment is recognised as an asset if, and only if, it is probable that future economic benefits or service potential associated with the item will flow to the Ministry and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

Disposals

Gains and losses on disposals are determined by comparing the sale proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the Statement of Comprehensive Revenue and Expense. When revalued assets are sold, the amounts included in asset revaluation reserves in respect of those assets are transferred to retained earnings.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the Ministry and the cost of the item can be measured reliably.

Intangible assets

Intangible assets are initially recorded at cost. The cost of an internally generated intangible asset represents expenditure incurred in the development phase of the asset only. The development phase occurs after the following can be demonstrated: technical feasibility; ability to complete the asset; intention and ability to sell or use; and where development expenditure can be reliably measured. Expenditure incurred on research related to an internally generated intangible asset is expensed when it is incurred. Where the research phase cannot be distinguished from the development phase, the expenditure is expensed when it is incurred.

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use by the Ministry are recognised as an intangible asset. Direct costs include the software development, employee costs, and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Intangible assets with finite lives are subsequently recorded at cost less any amortisation and impairment losses. Amortisation is charged to the Statement of Comprehensive Revenue and Expense on a straight-line basis over the useful life of the asset. Typically, the estimated useful lives of assets are as follows:

	Useful life	Amortisation rate
Software – internally generated	3–7 years	14.3–33.3%
Software – other	3–7 years	14.3–33.3%

Realised gains and losses arising from disposal of intangible assets are recognised in the Statement of Comprehensive Revenue and Expense in the period in which the transaction occurs.

Impairment of property, plant and equipment and intangible assets

The Ministry does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Intangible assets subsequently measured at cost that have an indefinite useful life or are not yet available for use, are not subject to amortisation and are tested annually for impairment.

Property, plant, and equipment and intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is the present value of the asset's remaining service potential. Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable service amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Leases

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset.

Lease incentives received are recognised evenly over the term of the lease as a reduction in rental expense.

Leasehold improvements are capitalised and the cost is amortised over the unexpired period of the lease, or the estimated useful life of the improvements whichever is shorter.

Provisions

The Ministry recognises a provision, based on probable cost, for future expenditure of uncertain amount or timing where there is a present obligation (either legal or constructive) as a result of a past event.

Provisions are recorded at the best estimate of the expenditure required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. Provisions to be settled beyond 12 months are recorded at their present value.

Commitments

Expenses yet to be incurred on non-cancellable contracts that have been entered into on or before balance date are disclosed as commitments to the extent that there are equally unperformed obligations. Cancellable commitments that have penalty or exit costs explicit in the agreement on exercising that option to cancel are included in the statement of commitments at the value of that penalty or exit cost.

Changes in accounting policies

There have been no accounting policy changes in the year.

Comparative figures

When presentation or classification of items in the financial statements is amended or accounting policies are changed, comparative figures are restated to ensure consistency with the current period unless it is impracticable to do so.

Goods and Service Tax (GST)

All items in the financial statements are stated exclusive of GST, except for receivables and payables, which are stated on a GST inclusive basis. Where GST is not recoverable as input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, Inland Revenue (IRD) as at balance date is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received, from IRD including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

Note 2: Revenue – other

Actual		Actual	Unaudited budget	Unaudited forecast
2015		2016	2016	2017
\$000		\$000	\$000	\$000
8,567	Medicines registration	7,788	8,400	8,400
635	Service fees	315	600	600
1,979	Annual licence and registration fees	2,042	1,900	4,016
–	Other government departmental revenue	–	–	–
802	Other revenue	543	3,257	–
11,983	Total revenue other	10,688	14,157	13,016

Note 3: Personnel

Actual		Actual	Unaudited forecast
2015		2016	2017
\$000		\$000	\$000
105,318	Salaries and wages	107,405	107,000
3,338	Employer contributions to defined contribution plans	3,319	3,400
1,875	Increase / (decrease) in employee entitlements	(746)	–
2,518	Other	3,676	3,615
113,049	Total personnel costs	113,654	114,015

Note 4: Capital charge

The Ministry pays a capital charge to the Crown on its equity (adjusted for memorandum accounts) as at 30 June and 31 December each year. The capital charge rate for the year ended 30 June 2016 was 8.0% (2015: 8.0%).

Note 5: Other operating expenses

Actual		Actual	Unaudited budget	Unaudited forecast
2015		2016	2016	2017
\$000		\$000	\$000	\$000
366	Fees to Audit New Zealand for the audit of the financial statements	376	370	370
19,976	Computer services	19,599	19,700	19,700
12,218	Contractors and consultants	14,071	12,000	14,000
8,022	Operating lease payments	7,488	7,900	7,900
4,663	Domestic travel	4,065	4,600	4,600
526	Overseas travel	339	500	500
21,770	Other operating expenses	16,945	20,744	22,005
67,541	Total other operating expenses	62,883	65,814	69,075

Note 6: Plant, property and equipment

	Land \$000	Buildings/ leasehold improvements \$000	Furniture, plant and equipment \$000	Motor vehicles \$000	Computer hardware \$000	Total \$000
Cost or valuation						
Balance as at 1 July 2014	5,300	9,109	6,876	373	19,649	41,307
Additions	–	3,990	1,871	–	227	6,088
Revaluation increase/(decrease)	(500)	–	–	–	–	(500)
Disposals	–	(2,390)	(3,677)	–	(943)	(7,010)
Transfers	–	–	–	–	1,376	1,376
Balance as at 30 June 2015	4,800	10,709	5,070	373	20,309	41,261
Balance as at 1 July 2015	4,800	10,709	5,070	373	20,309	41,261
Additions	–	5,259	(73)	–	2	5,188
Revaluation increase/(decrease)	550	–	–	–	–	550
Disposals	–	–	(1,808)	–	(540)	(2,348)
Transfers	–	(630)	–	–	630	–
Balance as at 30 June 2016	5,350	15,338	3,189	373	20,401	44,651
Accumulated depreciation and impairment losses						
Balance as at 1 July 2014	–	5,747	5,048	211	17,817	28,823
Depreciation expense	–	1,517	512	28	1,114	3,171
Eliminate on disposals	–	(2,072)	(3,392)	–	(943)	(6,407)
Transfers	–	–	–	–	1,166	1,166
Balance as at 30 June 2015	–	5,192	2,168	239	19,154	26,753
Balance as at 1 July 2015	–	5,192	2,168	239	19,154	26,753
Depreciation expense	–	2,435	445	24	853	3,757
Eliminate on disposals	–	–	(208)	–	(537)	(745)
Transfers	–	(600)	–	–	600	–
Balance as at 30 June 2016	–	7,027	2,405	263	20,070	29,765
Carrying amounts (includes work in progress)						
At 30 June 2014	5,300	3,362	1,828	162	1,832	12,484
At 30 June 2015	4,800	5,517	2,902	134	1,155	14,508
At 30 June 2016	5,350	8,311	784	110	331	14,886
Work in progress						
At 30 June 2014	–	–	16	–	6	22
At 30 June 2015	–	1,029	89	–	64	1,182
At 30 June 2016	–	6,148	11	–	6	6,165

The land at 108 Victoria Street, Christchurch was valued by Knight Frank, an independent valuer. The effective date of the evaluation is 30 June 2016. There has been an increase of \$550k to the value of this land.

There are no restrictions over the title of the Ministry's PPE.

Note 7: Intangible assets

	Acquired software \$000	Internally generated software \$000	Total \$000
Cost			
Balance as at 1 July 2014	18,938	63,121	82,059
Additions	–	6,665	6,665
Disposals	–	(3)	(3)
Transfers	–	(1,376)	(1,376)
Balance as at 30 June 2015	18,938	68,407	87,345
Balance as at 1 July 2015	18,938	68,407	87,345
Additions	129	6,218	6,347
Disposals	–	(490)	(490)
Transfers	–	–	–
Balance as at 30 June 2016	19,067	74,135	93,202
Accumulated amortisation and impairment losses			
Balance as at 1 July 2014	15,555	30,841	46,396
Amortisation expense	1,665	5,128	6,793
Disposals	–	(3)	(3)
Transfers	–	(1,166)	(1,166)
Balance as at 30 June 2015	17,220	34,800	52,020
Balance as at 1 July 2015	17,220	34,800	52,020
Amortisation expense	1,492	5,941	7,433
Disposals	–	(490)	(490)
Transfers	–	–	–
Balance as at 30 June 2016	18,712	40,251	58,963
Carrying amounts (includes work in progress)			
At 30 June 2014	3,383	32,280	35,663
At 30 June 2015	1,718	33,607	35,325
At 30 June 2016	355	33,884	34,239
Work in progress			
At 30 June 2014	–	11,344	11,344
At 30 June 2015	–	10,998	10,998
At 30 June 2016	–	10,825	10,825

There are no restrictions over the title of the Ministry's intangible assets.

Note 8: Creditors and payables

Actual		Actual	Unaudited forecast
2015 \$000		2016 \$000	2017 \$000
1,936	Creditors	224	200
2,453	Revenue in advance	2,167	2,086
9,490	Accrued expenses	8,245	10,174
1,486	GST payable	1,095	1,581
15,365	Total creditors and other payables	11,731	14,041

Creditors and other payables are non-interest bearing and are normally settled in the following month. Therefore, the carrying value of creditors and other payables approximates their fair value.

Revenue in advance are fees received in advance in relation to new medicine applications.

Note 9: Provision for repayment of surplus to the Crown

Actual		Actual	Unaudited forecast
2015 \$000		2016 \$000	2017 \$000
(605)	Net surplus/(deficit) before other expenses	(693)	–
	Add:		
235	(Surplus) / deficit of memorandum accounts	1,301	–
(370)	Total operating surplus / (deficit)	608	–
–	Total operating surplus to be returned to Crown	608	–

Note 10: Provisions

Actual		Actual	Unaudited forecast
2015 \$000		2016 \$000	2017 \$000
	Current provisions are represented by:		
184	Performance incentive	–	–
372	Assets to be written-off	372	500
239	Redundancies	1,346	–
–	Lease exit makegood	1,666	–
337	Other	307	–
1,132	Total current portion	3,691	500
	Non-current provisions are represented by:		
2,720	Lease exit makegood	–	–
30	ACC Partnership Programme	30	30
2,750	Total non-current portion	30	30
3,882	Total provisions	3,721	530

	Performance incentive \$000	Lease exit makegood \$000	Assets to be written-off \$000	Redundancies \$000	Other \$000	Total \$000
Opening balance 1 July	184	2,720	372	239	367	3,882
Additional provision made	–	–	–	1,346	–	1,346
Amounts applied	(184)	–	–	(239)	(30)	(453)
Unused amounts reversed	–	(1,054)	–	–	–	(1,054)
Closing balance 30 June	–	1,666	372	1,346	337	3,721

Note 11: Employee entitlements

Actual 2015 \$000		Actual 2016 \$000	Unaudited forecast 2017 \$000
	Current employee entitlements are represented by:		
6,668	Annual leave	6,354	5,259
424	Sick leave	383	1,236
1,046	Retirement and long service leave	1,007	916
702	Accrued salaries	418	589
8,840	Total current portion	8,162	8,000
	Non-current employee entitlements are represented by:		
1,411	Retirement and long service leave	1,343	1,438
1,411	Total non-current portion	1,343	1,438
10,251	Total employee entitlements	9,505	9,438

The present value of the retirement and long service leave entitlements depend on a number of factors that are determined on an actuarial basis using a number of assumptions. Two key assumptions applied when calculating this liability include the discount rates and the salary inflation factors. Any changes in these assumptions will have significant impact on the carrying value of the liability.

The discount rates used are taken from the Treasury's centrally produced risk free discount rates. The methodology of how these rates are calculated is provided on the Treasury website. The short term salary inflation factor has been determined after considering historical salary inflation patterns and current budgeting predictions. The long term salary assumption is a Treasury provided figure.

If the discount rates were to differ by 1 percentage point from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability would be an estimated average \$89,359 higher/lower.

If the salary inflation rates were to differ by 1 percentage point from the Ministry's estimates, with all other factors held constant, the carrying amount of the total liability would be an estimated average \$122,560 higher/lower.

Note 12: Equity

Equity comprises three components: taxpayers' funds, revaluation reserves and memorandum accounts.

Actual		Actual	Unaudited forecast
2015 \$000		2016 \$000	2017 \$000
	Taxpayers' funds		
29,012	Balance at 1 July	30,159	30,767
(605)	Surplus/(deficit)	(693)	–
235	Transfer of memorandum account net deficit for the year	1,301	–
–	Return of operating surplus to the Crown	(608)	–
1,517	Capital injection	–	–
30,159	Balance at 30 June	30,159	30,767
	Revaluation reserves		
2,540	Balance at 1 July	2,040	2,590
(500)	Revaluation gains/(losses) on land and building	550	–
2,040	Balance at 30 June	2,590	2,590
	Memorandum accounts		
3,095	Balance at 1 July	3,093	1,792
233	Transfer balance in discontinued account	–	–
(235)	Net memorandum account deficits for the year	(1,301)	–
3,093	Balance at 30 June	1,792	1,792
35,292	Total equity	34,541	35,149

Note 13: Reconciliation of the net surplus/(deficit) to the net cash from operating activities

Actual		Actual	Unaudited forecast
2015 \$000		2016 \$000	2017 \$000
(605)	Net surplus/(deficit)	(693)	–
	Add/(less) non-cash items:		
9,965	Depreciation and amortisation expense	11,190	10,000
	Net gains on derivative financial instruments	–	–
	Other non-cash items	–	–
	Net foreign exchange (gains) / losses	–	–
9,965	Total non-cash Items	11,190	10,000
	Add/(less) items classified as investing or financing activities:		
52	Net (gains)/losses on disposal of property, plant and equipment	(2)	–
52	Total items classified as investing or financing activities	(2)	–
	Add/(less) movements in working capital items:		
325	(Inc)/dec in debtors and receivables	486	(1,564)
–	(Inc)/dec in debtor Crown	9,242	1,458
1,524	(Inc)/dec in prepayments	464	(745)
1,722	Inc/(dec) in creditors and other payables	(3,604)	(814)
(204)	Inc/(dec) in provisions	(161)	(3,191)
–	Inc/(dec) in deferred liabilities	–	
(1,486)	Inc/(dec) in employee entitlements	(746)	(67)
1,881	Net movements in working capital items	5,681	(4,923)
11,293	Net cash from operating activities	16,176	5,077

Note 14: Related party transactions

The Ministry is a wholly owned entity of the Crown.

Related party disclosures have not been made for transactions with related parties that are within a normal supplier or client/recipient relationship on terms and condition no more or less favourable than those that it is reasonable to expect the Ministry would have adopted in dealing with the party at arm's length in the same circumstances. Further, transactions with other government agencies (for example, government departments and Crown entities) are not disclosed as related party transactions when they are consistent with the normal operating arrangements between government agencies and undertaken on the normal terms and conditions for such transactions.

Key management personnel compensation

Actual 2015 \$000		Actual 2016 \$000
	Leadership Team, including the Chief Executive	
2,545	Remuneration	3,690
8	Full-time equivalent staff	10

The above key management personnel disclosure excludes the Minister of Health. The Minister's remuneration and other benefits are not received only for his role as a member of the key personnel of the Ministry. The Minister's remuneration and other benefits are set by the Remuneration Authority under the Civil List 1979 and are paid under Permanent Legislative authority, and not paid by the Ministry of Health.

In December 2015, the Ministry of Health announced details of a new executive leadership structure to take effect on 1 March 2016. The 2016 figures include remuneration paid to former executive leadership members. Changes to the Ministry's leadership structure will enable the Ministry to support the health sector to face the challenges of changing demographics, changing burden of disease, and rapid changes in technology.

Note 15: Events after the balance sheet date

There are no significant events after the balance date.

Note 16: Liquidity risk

Liquidity risk is the risk that the Ministry will encounter difficulty with raising liquid funds to meet its payment commitments as they fall due.

In meeting its liquidity requirements the Ministry closely monitors its forecast cash requirements with expected cash draw-downs from the New Zealand Debt Management Office. The Ministry maintains a target level of available cash to meet its liquidity requirements.

The table below analyses the Ministry's financial liabilities that will be settled based on the remaining period at the balance date to the contracted maturity date. The amounts disclosed are the contracted undiscounted cash flows.

	Less than 6 months \$000	Between 6 months and 1 year \$000	Between 1 and 5 years \$000	Over 5 years \$000
2015				
Creditors and other payables	15,365	–	–	–
2016				
Creditors and other payables	11,731	–	–	–

Note 17: Memorandum accounts

The accumulated surpluses/(losses) during the year result in a net increase/(decrease) in the memorandum accounts of (\$1,300).

Summary of memorandum accounts

Opening balance

Problem Gambling	(516)
Office of Radiation Safety	973
Medsafe	2,636
Opening equity balance	3,093

2015/16 revenue and appropriation

Problem Gambling appropriation	1,001
Office of Radiation Safety revenue	919
Medsafe revenue	7,427
	9,347

2015/16 expenditure

Problem Gambling expenditure	1,000
Office of Radiation Safety expenditure	873
Medsafe expenditure	8,775
	10,648

2015/16 transfers

PsychoActive Substances	–
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Closing balance

Problem Gambling	(515)
Office of Radiation Safety	1,019
Medsafe	1,288
Closing equity balance	1,792

Problem gambling departmental

Since October 2004 the Ministry has, in accordance with the Gambling Act 2003, received an appropriation for problem gambling that over time is intended to be fully funded from the levies collected from the industry, on behalf of the Crown, by the IRD. The departmental balance in the problem gambling memorandum account as at 30 June 2016 is (\$515,000).

Actual 2015 \$000		Actual 2016 \$000
	Problem gambling departmental expenditure	
(433)	Balance 1 July	(516)
979	Revenue*	1,001
(1,062)	Expenses	(1,000)
(516)	Balance 30 June	(515)

* Revenue is as specified in the "Preventing and Minimising Gambling Harm: Three-year service plan 2013/14–2015/16".

Office of Radiation Safety: licensing activities

Following the sale of the National Radiation Laboratory to ESR the Ministry has retained a range of regulatory activities including licensing, issuing consents and maintenance of codes of safe practice, which now fall under the Office of Radiation Safety.

A memorandum account was established on 1 July 1998 for licensing activities required by the Radiation Protection Act 1965. The following table shows the amounts of revenue and expenses relating to licensing activities.

Actual 2015 \$000		Actual 2016 \$000
	Licensing fees	
702	Balance at 1 July	973
897	Revenue	919
(626)	Expenses	(873)
973	Balance at 30 June	1,019

Medsafe

Pursuant to the Medicines Act 1981, Medsafe derives third-party fee revenue from the medicines and pharmaceutical industry from licence applications to approve new or changed medicines, and for clinical trials. A memorandum account has been established effective from 1 July 2007 to match accumulated licence revenue collected against the expenses incurred to process applications. This information will be used to ensure that, over time, fees will be set at a level as to ensure revenue collected equates to equivalent levels of costs incurred.

Actual 2015 \$000		Actual 2016 \$000
	Medsafe	
3,059	Balance 1 July	2,636
8,318	Revenue	7,427
(8,741)	Expenses	(8,775)
2,636	Balance 30 June	1,288

Note 18: Explanation of major variances against budget

Explanations for major variances from the Ministry's estimated figures are as follows.

Statement of Comprehensive Revenue and Expense

Revenue Crown

Revenue Crown was \$645,000 higher than the unaudited budget. This was mainly due to additional funding for social bonds and the transfer to the Ministry of elements of Canterbury Earthquake Authority (CERA) following its disestablishment, offset by the Ministry's contribution to the Budget 2015 Systems Package.

Revenue other

Revenue other was \$3.469 million lower than the unaudited budget, mostly because the Natural Health and Supplementary Products and Psychoactive Substances regulators are not yet generating revenue.

Depreciation

Depreciation costs were \$793,000 higher than the unaudited budget mainly due to the impairment of assets.

Statement of financial position

Current assets

Current assets, comprising cash and cash equivalents, debtors and other receivables and prepayments were \$3.455 million lower than the unaudited budget. This was mainly due to debtors and receivables being lower than expected, partially offset by cash and cash equivalents being \$4.423 million higher than expected.

Property, plant and equipment, and intangible assets

Property, plant and equipment, and intangible assets were \$1.811 million lower than the unaudited budget. This is mainly because intangible assets were lower than the Main Estimates due delays in completion of projects.

Statement of cash flows

Net Increase in cash and cash equivalents held

Cash and cash equivalents increased \$4.423 million higher than the Main Estimates. This was mainly due to net cash provided from operating activities being \$3.198 million higher than the Main Estimates, because Receipts from the Crown Revenue were \$7.388 million higher than the Main Estimates, partially offset by Receipts from Other Revenue being \$3.601 million lower due to lower revenue received; and unbudgeted receipts from sales of assets of \$1.575 million.

Non-departmental statements and schedules for the year ended 30 June 2016

The following non-departmental statements and schedules record the revenue, expenses, assets, liabilities, commitments, contingent liabilities, contingent assets and trust accounts that the Ministry manages on behalf of the Crown.

Statement of non-departmental expenses and capital expenditure against appropriations for the year ended 30 June 2016

Actual 2015 \$000		Actual 2016 \$000	Main estimates 2016 \$000	Voted [^] appropriation 2017 \$000
	Non -departmental output expenses			
11,444,185	Health and disability support services for District Health Boards	11,791,121	11,719,827	11,797,847
2,680,741	National Services	2,785,840	2,824,540	2,802,197
26,480	Non-departmental other expenses *	35,191	28,472	25,653
676,384	Non-departmental capital contributions to other persons or organisations	485,621	1,088,100	650,458
14,827,790	Total non-departmental appropriations	15,097,773	15,660,939	15,276,155

[^] These amounts include adjustments made in the Supplementary Estimates and adjustments made under the Public Finance Act 1989.

* This amount includes \$9.884 million of unappropriated expenditure as disclosed in the Statement of non-departmental unappropriated expenses and capital expenditure.

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules. For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016. Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Schedule of non-departmental revenue and capital receipts for the year ended 30 June 2016

Non-departmental revenues and capital receipts are administered by the Ministry on behalf of the Crown. As these revenues are not established by the Ministry nor earned in the production of the Ministry's outputs, they are not reported in the Ministry's financial statements.

Actual 2015 \$000		Actual 2016 \$000	Main estimates 2016 \$000	Supp. estimates 2017 \$000
	Revenue			
	Reimbursement from the ACC⁺			
5,599	ACC – reimbursement of complex burns costs	4,839	5,599	5,734
29,271	ACC – reimbursement of work-related public hospital costs	29,036	29,994	29,902
276,398	ACC – reimbursement of non-earners' account	275,846	281,722	280,818
83,901	ACC – reimbursement of earners' non-work-related public hospital costs	87,109	85,972	85,709
69,506	ACC – reimbursement of motor vehicle-related public hospital costs	72,591	71,221	71,003
2,554	ACC – reimbursement of medical misadventure costs	4,839	2,618	2,610
7,992	ACC – reimbursement of self-employed public hospital costs	9,679	8,190	8,165
475,221	Total ACC reimbursements	483,939	485,316	483,941
194,350	Payment of capital charge by DHBs	203,941	204,143	205,247
(37,207)	Net surplus/(deficit) from DHBs*	(55,032)	–	–
4,492	Other Crown entities surplus/(deficits)**	3,041	–	–
636,856	Total non-departmental revenue	635,889	689,459	689,188
	Capital receipts			
14,701	Repayment of residential care loans	11,549	15,000	15,000
600	Repayment of DHB debt	600	–	–
132,499	Equity repayments by DHBs	12,499	12,499	12,499
147,800	Total non-departmental capital receipts	24,648	27,499	27,499
784,656	Total non-departmental revenue and capital receipts	660,537	716,958	716,687

+ Accident Compensation Corporation.

* Based on unaudited financial statements of the 20 DHBs: accordingly these have not been reflected in the investments in Crown entities figure within the schedule of non-departmental assets.

** Based on unaudited financial statements of the other non-DHB health sector Crown entities: accordingly these have not been reflected in the Investments in Crown entities figure within the schedule of non-departmental assets.

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Schedule of non-departmental assets and liabilities as at 30 June 2016

Actual 2015 \$000	Note	Actual 2016 \$000	Main estimates 2016 \$000	Supp. estimates 2017 \$000
Assets				
Current assets				
125,654		107,514	95,000	95,000
20,558	2.12	17,383	21,903	20,558
Debtors and other receivables:				
275		55	10,000	-
		18,552	-	-
945		1,195	134	945
3,012		2,251	2,922	1,962
12,496		33,239	21,455	12,496
162,940		180,189	151,414	130,961
Non-current assets				
Advances:				
35,426	2.13	36,355	39,702	40,000
3,038		2,438	7,053	2,554
Investments:				
161,505	2.14	314,039	441,161	346,810
33,783		33,783	24,225	20,910
233,752		386,615	512,141	410,274
396,692		566,804	663,555	541,235
Liabilities				
Current liabilities				
Creditors and other payables:				
4,845		20,114	-	-
19,761	2.15	35,397	-	-
Accrued liabilities and provisions:				
219,138		195,423	233,575	232,267
1,079		1,147	-	-
165,802		158,329	240,815	168,790
410,625		410,410	474,390	401,057

In addition, the Ministry monitors a number of Crown entities (including the 20 DHBs). The investment in those entities is recorded in the financial statements of the Government on a line-by-line basis. No disclosure of investments in Crown entities is made in this schedule.

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Schedule of non-departmental commitments as at 30 June 2016

The Crown has the following capital commitments.

Actual 2015 \$000		Actual 2016 \$000
	Capital commitments	
123,108	Property, plant and equipment	334,349
–	Intangible assets	–
–	Other capital commitments	–
123,108	Total capital commitments	334,349
123,108	Total commitments	334,349

Schedule of non-departmental contingent liabilities and contingent assets as at 30 June 2016

Quantifiable contingent liabilities

Actual 2015 \$000		Actual 2016 \$000
6,030	Legal proceedings and disputes	1,025
6,030	Total quantifiable contingent liabilities	1,025

Legal proceedings and disputes

Legal claims against the Crown are mainly seeking recompense in relation to perceived issues regarding treatment and care. The Crown is in the process of defending these claims. In the normal course of events previous experience indicates that any settlements are likely to be significantly less than the claims made.

Contingent assets

The Ministry on behalf of the Crown has no contingent assets as at 30 June 2016 (2015: Nil).

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Problem Gambling Levy Report for the year ended 30 June 2016

Since October 2004 the Ministry has, in accordance with the Gambling Act 2003, received an appropriation for problem gambling that over time is intended to be fully funded from the levies collected from the industry, on behalf of the Crown, by the IRD. The following report shows the IRD levies collected to date and actual expenditure in relation to problem gambling. The balance in the problem gambling memorandum account as at 30 June 2016 is (\$1.736) million.

Actual 2015 \$000		Non-departmental actual 2016 \$000	Departmental actual 2016 \$000	Total actual 2016 \$000
	Problem gambling non-departmental expenditure			
(1,354)	Balance at 1 July	164	(516)	(352)
17,799	Revenue*	16,820	1,001	17,821
(16,797)	Expenses	(18,205)	(1,000)	(19,205)
(352)	Balance at 30 June	(1,221)	(515)	(1,736)

* Revenue is actual levies collect by IRD, less the Departmental revenue based on the "Preventing and Minimising Gambling Harm: Three-year service plan 2013/14–2015/16".

Statement of trust monies for the year ended 30 June 2016

Actual 2015 \$000		Actual 2016 \$000
	District Health Boards Deposit Trust Account*	
875	Balance as at 1 July	1,088
6,993,705	Contributions	7,324,487
(6,994,224)	Distributions	(7,324,151)
–	Revenue	–
732	Expenditure	(500)
1,088	Balance as at 30 June	924

* This trust account was set up to hold funds received from DHBs for the delivery of processing services and disbursements.

Another trust account was set up to hold deposits made by those new medicines applications that have been rejected by the Medicines Assessment Advisory Committee (MAAC). Deposits are made when applicants request the Medicines Review Committee to consider their objections to recommendations made by MAAC. Once the Medicines Review Committee has completed its review, these deposits are refunded to depositors subject to the deduction of any costs ordered by the Committee. The balance of this trust account remains under \$500.00 and is not significant enough to show separately.

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Statement of non-departmental unappropriated expenses and capital expenditure for the year ended 30 June 2016

Non-departmental capital expenditure to be incurred by the Crown

Health Sector Projects	\$'000
<i>1 July 2013 – 30 June 2014</i>	6,380
<i>1 July 2014 – 30 June 2015</i>	1,221
<i>1 July 2015 – 30 June 2016</i>	726
Write off of costs on transfer value of Burwood Hospital	1,557

Approval of the above unappropriated expenditure has been sought under section 26C of the Public Finance Act 1989.

The reason for the unappropriated expenditure across 3 financial years is due to corrections made to the accounting treatment for costs incurred for pre-business case work associated with the Burwood Hospital, Christchurch Hospital, Grey Hospital and the Southern Redevelopment Project hospital redevelopments. It has been identified that some costs associated with these projects, to comply with New Zealand generally accepted accounting practice, have been reclassified as operating expenses and could not be allocated to the capital expenditure appropriation. No operating expenditure appropriation for these costs exists.

Costs capitalised by the Ministry of Health associated with the external project management of Burwood Hospital did not form part of the final agreed transfer amount. This amount is required to be written off.

The accompanying notes on pages 111 to 114 are an integral part of these financial statements and schedules.

For a full understanding of the Crown's financial position and the results of its operations for the period, reference should be made to the consolidated Financial Statements of the Government for the year ended 30 June 2016.

Reference should also be made to the separate Vote Health Report in relation to selected Non-departmental Appropriations completed in accordance with S19B of the Public Finance Act.

Notes to the non-departmental statements and schedules

Note 1: Statement of accounting policies for the year ended 30 June 2016

Reporting entity

These Non-departmental Statements and Schedules present financial information on public funds managed by the Ministry of Health on behalf of the Crown.

The financial information reported in these Schedules is consolidated into the Financial Statements of the Government, and therefore readers of these Schedules should also refer to the Financial Statements of the Government for the year ended 30 June 2016.

Basis of preparation

The Non-departmental Statements and Schedules have been prepared in accordance with the accounting policies of the Financial Statements of the Government, Treasury Instructions and Treasury Circulars.

Measurement and recognition rules applied in the preparation of the Non-departmental Statements and Schedules are consistent with Crown accounting policies and Tier 1 NZ PBE accounting standards.

Measurement system

The non-departmental statements and schedules have been prepared on an historical cost basis modified by the revaluation of certain assets.

Revenue and receipts

Revenue from ACC recoveries and capital charges from DHBs is recognised when earned and is reported in the financial period to which it relates.

Debtors and receivables

Receivables from ACC recoveries are recorded at the value of the contract and agreed with ACC. Receivables from capital charges are recorded at estimated realisable value.

Residential care loans

An actuarial valuation of residential care loans was carried out in May 2016.

Inventory

Inventories held for consumption in the provision for services are recorded at the lower of cost or current replacement cost. Any write-down from cost to replacement cost is recognised in the Statement of Non-Departmental Expenses and Capital Expenditure against appropriations.

Investments

Investments are recorded in the Schedule of Non-Departmental Assets at historical cost. The carrying value represents the aggregate of equity injections made by the Ministry less subsequent repayments of equity returned to the Crown.

Accrued expenses

Accrued expenses are recorded at either the value of funding entitlements owing under Crown funding agreements or the estimated value of contracts already started but not yet completed.

Goods and services tax (GST)

All items in the financial statements, including appropriation statements, are stated exclusive of GST, except for receivables and payables, which are stated on a GST-inclusive basis. In accordance with Treasury Instructions, GST is returned on revenue received on behalf of Crown, where applicable. However, an input tax deduction is not claimed on non-departmental expenditure. Instead, the amount of GST applicable to non-departmental expenditure is recognized as a separate expense and eliminated against GST revenue on consolidation of the Financial Statements and Government.

Commitments

Future expenses and liabilities to be incurred on contracts that have been entered into as at balance date are disclosed as commitments to the extent that there are equally unperformed obligations.

Budget figures

The budget figures are consistent with the financial information in the Mains Estimates. In addition, these financial statements also present the updated budget information about the Supplementary Estimates.

Payables and provisions

Payables and provisions are recorded at the estimated obligation to pay.

Changes in accounting policies

There have been no changes in accounting policies.

Events after the balance date

There are no significant events after the balance date.

Note 2: Explanation of major variances against budget

Explanations for major variances from the Ministry's non-departmental appropriations within the Main Estimates are as follows.

Schedule of non-departmental expenses and capital expenditure against appropriations

2.1 National disability support services

The overspend of \$9.370 million of the Main Estimates is related to a demand increase in the disability support services including community living services and family and community services. The Supplementary estimates increased funding by \$8.905 million reducing the overspend to \$465,000. This was offset by a transfer of \$950,000 to this appropriation which was approved by the Minister of Finance under Section 26A of the Public Finance Act 1989.

2.2 Public health services purchasing

The underspend of \$55.379 million of the Main Estimates relates to the timing of projects in the Sanitary Works Subsidy Scheme and safe Water Schemes (\$26 million), transfers of funding to other appropriations (\$13 million) and other underspends (\$16 million).

2.3 National elective services

The overspend of \$6.668 million of the Main Estimates relates mainly \$8 million of additional funding for elective volumes transferred during the year from other appropriations.

2.4 National Maori Health Services

The underspend of \$3.242 million of the Main Estimates mainly relates to delays with contracting.

2.5 National Mental Health Services

The underspend of \$2.683 million of the Main Estimates mainly relates to funding devolved to DHBs during the year.

2.6 Primary Health Care Strategy

The overspend of \$7.485 million of the Main Estimates relates to increased volumes.

2.7 Deficit support for DHBs

The underspend of \$41 million of the Main Estimates relates to reduced need by DHBs for balance sheet funding of deficits.

2.8 Equity for capital projects for DHBs

The underspend of \$262.970 million of the Main Estimates relates to the timing of funding required for District Health Board capital projects. This appropriation holds capital funds pending their drawdown by DHBs to meet the funding requirements for capital projects approved by Cabinet or joint Ministers of Health and Finance. This funding has been carried forward for projects in out-years.

2.9 Health sector projects

The underspend of \$227.582 million of the Main Estimates is due to the timing of funding required for health sector capital projects mainly relating to the Canterbury Hospital Rebuild that are managed or co-managed by the Ministry. The underspend was carried forward to 2015/16 for work on the Canterbury hospital rebuild.

2.10 Loans for capital projects

The underspend of \$74 million of the Main Estimates relates to the timing of funding required for District Health Board capital projects. The underspend of \$23.345 of the Supplementary Estimates was due to the timing of funding for DHB capital projects. This underspend is expected to be transferred to 2016/17.

2.11 Refinance of Crown loans

The variance of \$7.420 million to the Main Estimates relates to short term loans that rolled over within the financial year. Additional funding was approved by the Cabinet.

Schedule of non-departmental assets

2.12 Inventory

Stocks of vaccines were \$4.520 million less than the Main Estimates, due to the write-off of out-of-date emergency stocks of vaccines.

2.13 Residential care loans

Residential care loans were \$3.347 million lower than the Main Estimates mainly due to the opening balance being \$3.451 million lower than forecast.

2.14 Christchurch and West Coast Hospital Rebuild Project

Christchurch and West Coast Hospital Project was \$107.354 million lower than the Main Estimates due to the timing of the project.

Schedule of non-departmental liabilities

2.15 Other payables

Other payables were not provided for in the Main Estimates.

Organisational health and capability

In order for the Ministry to achieve its strategic direction it must be supported by the right people, in the right places with the right capability. Other important enabling functions that support achievement of the Ministry's priorities occur in the areas of IT, finances and capital. The refresh of the New Zealand Health Strategy is beginning to have a significant impact in determining the future direction of our health system and the Ministry.

The State Services Commission (SSC) has scheduled the Ministry for a Performance Improvement Framework (PIF) review during the 2016/17 financial year. This review will provide the Ministry with the information about progress it has made since its first PIF review in 2012 and also provide guidance on further improvements.

Developing our story

The Ministry has embarked on a comprehensive transformation journey to support the refresh of the New Zealand Health Strategy, with the first stage being the appointment of a new Executive Leadership Team. This journey will continue over the foreseeable future as we transform all of the business units to be better equipped to take the Ministry into the next 10 years.

Our story is to ***lead, shape, deliver.***

Part of this journey has seen the development of an organisational strategy designed to better understand our Purpose, Vision and Mission. This has led to beginning to better understand the culture and values needed to take the Ministry forward. These will be embedded in the refresh of our competency framework, which will form the basis of the performance management system that will take the Ministry from good to great.

Recruitment and retention

The Ministry has completed its move to a centralised recruitment function as part of the all-of-government recruitment contract to provide recruitment expertise to hiring managers. The implementation of an online recruitment tool, combined with the development of online forms, has reduced administrative time.

People and capability enhancement

The Ministry is making key changes to staff development and performance mechanisms. It is enhancing its performance and development framework to help managers to have consistent, effective performance and development conversations with their teams covering both key organisational and individual deliverables and behaviours.

It is developing a realigned competency model to identify the critical skills and competencies needed in the Ministry, and has applied it to all position descriptions and performance review conversations.

The Ministry has continued its capability development programme by targeted learning programmes for leadership, management and core skills.

Equal employment opportunities

The Ministry recognises that equality and diversity are important for organisational success. The differences that staff bring to the workplace represent benefits to the Ministry that need to be understood, appreciated and realised.

The Ministry's rules and processes for recruitment, selection, terms of employment, performance management, capability development and promotion aim to promote equity and diversity. The Ministry is proud to have a gender-balanced Executive Leadership Team. Further to this, all recruitment advertisements advise candidates that the Ministry is a disability-friendly organisation.

The Ministry remains committed to creating a diverse culture with a wide range of skills and perspectives. Table 17 shows the Ministry's people capability measures.

Table 17: People capability measures

Voluntary turnover	The 12-month gross rolling average turnover rate for 2015/16 was 14.8% for permanent staff, which is slightly over the Ministry's 14% per annum target.
Retention of new staff	74.5% of new staff are still in the Ministry after 12 months (including 20 employees who changed their role). This is higher than the Benchmarking Administrative and Support Services (BASS) percentage of 69.5%.
Sick leave	Average days of absence per employee (excluding maternity/paternity leave) is 8.3 days, which is higher than the BASS median of 6.84 days in 2013 and close to the public sector average of 8 days per annum per person.

Information technology (IT)

The Ministry provides key information and IT support to the health and disability system, especially through:

- the provision of national infrastructure systems
- a payments service to the health and disability sector.

The Ministry directly and indirectly supports the operating intentions, outcomes and objectives that underpin the health and disability system's ability to operate effectively. Specifically, the Ministry:

- operates national IT systems and payment systems for the health and disability sector
- maintains national collections and information management services for researchers and analysts
- provides eHealth leadership for the sector
- provides information services to 1150 knowledge workers within the Ministry.

The Ministry is delivering a range of national health IT initiatives supporting policy implementation, such as In-between Travel Payments for Home Carers and Under 13's free health care. Other significant initiatives include:

- continuing increase in online access to NHI through organisations joining, such as St John
- development and implementation of services required to support the National Enrolment Service initiative, and actively assisting vendor integration of the services into GP practice management systems
- development and implementation of a process for validating and aggregating PHO data received as part of the Integrated Performance Incentive Framework, and outputting the data as consolidated Service Utilisation and Clinical Performance data sets for Ministry reporting and analysis.

Procurement strategy

The Ministry continues to focus on internal procurement capability. The commitment to improve the effectiveness of interventions and develop new procurement models to get better outcomes from available government funding has been realised through several key projects, such as the Social Bonds pilot and NGO streamlined contracting.

The Procurement Improvement Programme continues to enhance Ministry procurement planning and supplier selection and contracting, as well as refining the implementation and monitoring of service contracts and providing better support for Ministry staff involved in procurement processes. The recommendations from the procurement effectiveness review, undertaken as part of the Government Procurement Functional Reform Programme, have been dovetailed into relevant workstreams under the Ministry's improvement programme.

The future scope for better procurement efficiency and effectiveness is being driven by the Ministry change programme, with the formation of the new Service Commissioning Business Unit, where the focus for procurement activity is better aligned to Ministry outcomes. Oversight from the Ministry of Business, Innovation & Employment will come through the Procurement Capability Index, which will be demonstrated by the Treasury Investor Confidence Rating for the Ministry.

Property management

The Wellington relocation project concludes in the coming year, which will see the completion of the major redesign and refit of the 133 Molesworth Street building, which will house all of our Wellington people.

The Ministry is also relocating its Christchurch-based staff back into the central business district as part of the Christchurch Integrated Government Accommodation (CIGA) project. The Ministry will co-locate with the Ministry of Education. This project is on track to be completed in April 2017.

Both projects are being delivered under the leadership of the Ministry, with support from the Government Property Group within the Ministry of Business, Innovation and Employment as part of an all-of-government approach.

Business continuity

The Ministry maintains a business continuity management system, which is aligned with the international business continuity management standard ISO 22301:2012. The Ministry's business continuity management process follows a continuous cycle of identifying priorities, analysing requirements, planning, implementing and reviewing.

A key output of the process is a business continuity plan. Due to the size and complexity of the Ministry, we have a framework that covers different components of planning in separate plans. Together the suite of plans forms a comprehensive holistic plan for the Ministry. The plans also allow the greatest flexibility to manage events of varying type, scale and impact.

In 2015/16 the Ministry continued to build awareness and understanding of business continuity management through its annual training, education and awareness programme, including participation in NZ ShakeOut, the nationwide earthquake drill. The second half of 2015/16 has focused on ensuring the business continuity plans are refreshed and aligned to the new structure of the Ministry to ensure a continued ability to manage any business disruptions that occur.

Managing risk

As the Ministry continues along its transformation journey there are likely to be a range of new challenges and opportunities. In such an environment of change we recognise the importance of effective risk management approaches and practices to ensure we remain on track and focused on delivering our strategic intentions.

The Ministry has continued to maintain an active and structured programme of risk management and internal control across its operations for which all managers and staff are responsible. Our focus during the year has been on proactively identifying and managing key risks and capitalising on opportunities, both in relation to our business-as-usual activities and those emerging from our transformation programme.

The Ministry has an established risk management framework, which is aligned to the international risk management standard AS/NZ ISO 31000:2009. It encourages a combined top-down, bottom-up and Ministry-wide approach, where risk information is used to inform our decision-making and help us achieve our goals. The framework is supported by an approach focused on keeping risk relevant and jargon-free, and which helps promote a risk-aware culture at all levels of the Ministry. The Ministry has continued to build this 'risk ready' culture via its ongoing risk education programme aimed at enhancing risk awareness in our day-to-day work.

The Ministry's dedicated risk function is focused on supporting the Ministry to continue to build its risk-management maturity via an extensive programme of activity. In 2015/16 this included:

- developing a virtual team of skilled 'risk champions' to provide additional risk support, advice and training within the business units
- aligning key risk information to the Ministry's new structures and Executive Leadership Team accountabilities
- refining internal risk reporting to promote the easy flow of risk information up, down and around the Ministry
- providing risk support to the transformation programme and other key programmes of work
- providing best practice advice, frameworks and tools.

The Ministry has reviewed the purpose, role and membership of the Audit, Finance and Risk Committee. The review was focused on ensuring this governance group is best placed to support and enable the achievement of our strategic intentions by providing quality, future-focused, independent strategic advice to the Director-General of Health on risk and assurance. A newly constituted committee commenced in August 2016 and will continue to focus on strengthening the Ministry's overall governance framework.

Assurance

The Ministry maintains an internal audit and assurance function. A Ministry team provides independent, objective assurance on the effectiveness of the Ministry's governance, planning, performance and risk management, operational processes and internal controls. It also identifies opportunities for improving the efficiency and effectiveness of how the Ministry uses its resources. The team's work programme is based on a rolling 18-month internal audit plan. Delivery against the plan remained substantially on track for 2015/16.

Emergency management

The Ministry maintains the capability and capacity to lead and coordinate a national health response to an emergency. In addition, it has maintained plans to continue functioning during and after an emergency, in accordance with sections 58 and 59 of the Civil Defence Emergency Management Act 2002 (which require all government departments to prepare such plans) and ensured ongoing maintenance of the stock that forms the national pandemic reserve supply.

A significant review and update of the National Health Emergency Plan (NHEP) was undertaken during 2015/16. The Plan provides the emergency management framework for the health and disability sector and describes the roles and responsibilities at all levels. The review was completed to ensure the NHEP meets international best practice and aligns with the updated National Civil Defence Emergency Management Plan Order.

Response activity

The Ministry's emergency response capability includes the ability to activate an emergency operations centre (the National Health Coordination Centre) if required. Response activity is scalable to meet the scope and impact of the event.

While there have been no declared national emergencies during this period, the Ministry has responded to a wide range of hazards and threats managed within the national security system. This has seen an effective collaborative response across teams in the Ministry, including the Office of the Director of Public Health, the Communicable Disease Team, the Environmental Health Team and Communications.

Key response activity included: response to the hepatitis A outbreak from contaminated frozen berries, monitoring and provision of national guidance relating to the World Health Organization (WHO) Public Health Emergency of International Concern for the Zika virus, support to DHBs for local events, and response to cyclones in the South Pacific.

The response to Tropical Cyclone Winston in February 2016 included the deployment of the New Zealand Medical Assistance Team (NZMAT), comprising six small teams of health sector and Ministry staff (totalling 22 staff) who were deployed as part of the New Zealand Government humanitarian response to Fiji.

Infant feeding in emergencies

A position statement on infant feeding in an emergency and consumer resources for parents and caregivers were published on the Ministry's website in December 2015. The consumer resources provide practical advice for those families with infants on how to prepare for and get through an emergency while ensuring infants remain healthy and well fed.

The need for this information was highlighted during the Christchurch earthquake in 2011. It was clear that New Zealand needed to clarify roles and responsibilities, provide clear advice on best practice, and address product donations and distribution to better align with our international obligations, as referred to in WHO's *Infant and Young Child Feeding in Emergencies*.

Emergency management, public health legislation and nutrition and physical activity teams worked closely on this project with the Ministry of Civil Defence and Emergency Management. This project required extensive consultation with the health sector, including DHB emergency planners, infant feeding experts, public health units, and NGOs who work with families that have infants.

Departmental capital and asset management intentions

Capital Investment Committee

The Capital Investment Committee is a section 11 committee which provides advice to the Director-General of Health and the Ministers of Health and Finance on capital investment and infrastructure in the public health sector in line with Government priorities. This includes working with DHBs to review their business case proposals, prioritisation of capital investment, delivery of a National Asset Management Plan, and any other matters the Minister may refer to it.

Additional information

Additional statutory reporting requirements

The Minister of Finance has not specified any additional reporting requirements.

Health Act 1956

The Health Act 1956 requires the Director-General of Health to report annually on the current state of public health. A Health and Independence Report is tabled each year in Parliament by the Minister of Health. The Minister is required to table the report by the 12th sitting day of the House of Representatives after the date on which the Minister receives the report. The Act also requires the Director-General to report before 1 July each year on the quality of drinking-water in New Zealand. Copies of the most recent report are made available to the public through the Ministry's website.

New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability Act 2000 requires the Minister of Health to report annually on the implementation of the New Zealand Health Strategy, the New Zealand Disability Strategy and the National Strategy for Quality Improvement. The Minister must make the report publicly available and present it to the House of Representatives as soon as practicable after the report has been made.

Public Finance Act 1989

Section 19B of the Public Finance Act 1989 requires the Minister to report annually on non-departmental expenditure relating to health sector agencies other than Crown entities. The Vote Health Report, in relation to selected non-departmental appropriations for the year ended 30 June 2015, will be tabled in Parliament by the Minister of Health within four months of the end of the financial year (by the end of October) or, if parliament is not in session, as soon as possible after the commencement of the next session of Parliament. Copies of the report will be made available to the public through the Ministry's website.

Other legislation

Other reporting requirements relate to the following legislation:

- Disabled Persons Community Welfare Act 1975
- Health Research Council Act 1990
- Human Assisted Reproductive Technology Act 2004
- Social Security Act 1964.

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Appendix A: Legal and regulatory framework

Legislation the Ministry administers

- Alcoholism and Drug Addiction Act 1966
- Burial and Cremation Act 1964
- Cancer Registry Act 1993
- Children's Health Camps Board Dissolution Act 1999
- Disabled Persons Community Welfare Act 1975 (Part 2A)
- Epidemic Preparedness Act 2006
- Health Act 1956
- Health and Disability Commissioner Act 1994
- Health and Disability Services (Safety) Act 2001
- Health Benefits (Reciprocity with Australia) Act 1999
- Health Benefits (Reciprocity with the United Kingdom) Act 1982
- Health Practitioners Competence Assurance Act 2003
- Health Research Council Act 1990
- Health Sector (Transfers) Act 1993
- Home and Community Support (Payment for Travel Between Clients) Settlement Act 2016
- Human Tissue Act 2008
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
- Medicines Act 1981
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Misuse of Drugs Act 1975
- New Zealand Council for Postgraduate Medical Education Act Repeal Act 1990
- New Zealand Public Health and Disability Act 2000
- New Zealand Public Health and Disability (Southern DHB) Elections Act 2000
- Psychoactive Substances Act 2013
- Radiation Protection Act 1965
- Radiation Safety Act 2016
- Sleepover Wages (Settlement) Act 2011
- Smoke-free Environments Act 1990
- Tuberculosis Act 1948

Other regulatory roles and obligations

In addition to administering legislation, key personnel within the Ministry (such as the Directors of Public Health and Mental Health) have specific statutory powers and functions under various pieces of legislation. The Ministry also has certain statutory roles and relationships defined in other legislation, including:

- Biosecurity Act 1993
- Civil Defence Emergency Management Act 2002
- Criminal Procedure (Mentally Impaired Persons) Act 2003
- Education Act 1989
- Food Act 1981
- Gambling Act 2003
- Hazardous Substances and New Organisms Act 1996
- Human Assisted Reproductive Technology Act 2004
- Land Transport Act 1998
- Litter Act 1979
- Local Government Act 2002
- Maritime Security Act 2004
- Prostitution Reform Act 2003
- Sale and Supply of Alcohol Act 2012
- Social Security Act 1964
- Victims' Rights Act 2002
- Waste Minimisation Act 2008.

International compliance

The Ministry helps the Government to comply with certain international obligations by supporting and participating in international organisations such as the World Health Organization. The Ministry also ensures New Zealand complies with particular international requirements, such as the International Health Regulations (2005) and the Framework Convention on Tobacco Control, and a range of United Nation conventions.

Regulations administered by the Ministry can be accessed on the Ministry website:
www.health.govt.nz

Full, searchable copies of the Acts and associated regulations administered by the Ministry can be found at: www.legislation.govt.nz

Appendix B:

Section 11 committees

Section 12(5) of the New Zealand Public Health and Disability Act 2000 requires that, in every Annual Report, the Ministry must specify the name, chairperson and members of all committees established under Section 11 of the Act.³⁶ This appendix fulfils that requirement.

Cancer Control New Zealand

Cancer Control New Zealand was disestablished in August 2015 because of the progress made in improving cancer services for New Zealanders.

Health Workforce New Zealand

Professor Des Gorman (Chair)

Ms Helen Pocknall (Deputy Chair)

Mrs Gloria Crossley

Dr David Kerr

Ms Stella Ward

Ms Sally Webb

Professor Tim Wilkinson

Dr Andrew Wong

National Health Board

The National Health Board was disestablished in March 2016 following an independent review as part of the development of the refreshed New Zealand Health Strategy.

National Health Committee

The National Health Committee was disestablished in March 2016 and their functions streamlined into the Ministry of Health.

Northern A Health and Disability Ethics Committee

Dr Brian Fergus (Chair)

Dr Karen Bartholomew

Ms Susan Buckland

Ms Shamim Chagani

Ms Christine Crooks

Mr Mark Smith (to September 2015)

Mr Kerry Hiini (to July 2015)

Ms Michèle Stanton (to July 2015)

Ms Rosemary Abbott (appointed March 2016)

³⁶ Section 11 committees are not DHB or Crown entity boards.

Ms Charis Brown (appointed November 2015)
Dr Kate Parker (appointed November 2015)

Northern B Health and Disability Ethics Committee

Ms Raewyn Sporle (Chair) (to November 2015)
Ms Kate O'Connor (Chair) (appointed December 2015)
Mrs Mali Erick
Mrs Phyllis Huitema
Miss Tangihaere Macfarlane
Mrs Stephanie Pollard
Dr Paul Tanser (to July 2015)
Ms Kerin Thompson (to July 2015)
Mr John Hancock (appointed December 2015)
Mrs Leesa Russell (appointed December 2015)
Dr Nora Lynch (appointed July 2015)

Central Health and Disability Ethics Committee

Mrs Helen Walker (Chair)
Mr Paul Barnett (to July 2015)
Dr Kay de Vries (resigned February 2015)
Mrs Gael Donoghue (to July 2015)
Ms Sandy Gill
Dr Patries Herst
Dr Dean Quinn
Dr Cordelia Thomas
Dr Angela Ballantyne (appointed July 2015)
Dr Peter Gallagher (appointed July 2015)

Southern Health and Disability Ethics Committee

Ms Raewyn Idoine (Chair)
Mrs Angelika Frank-Alexander
Dr Sarah Gunningham
Dr Nicola Swain
Dr Devonie Waaka
Dr Mathew Zacharias
Assoc. Prof. Mira Harrison-Woolrych (appointed September 2014)
Dr Fiona McCrimmon (appointed September 2014)

Ethics Committee on Assisted Reproductive Technology

Ms Kate Davenport (Chair) (to July 2015)
Ms Iris Reuvecamp (Chair) (appointed August 2015)
Dr Deborah Payne
Dr Freddie Graham
Dr Carolyn Mason
Dr Adriana Gunder (to May 2016)

Ms Jo Fitzpatrick
Dr Paul Copland (appointed August 2015)
Ms Michele Stanton (appointed August 2015)
Mrs Judith Charlton (appointed May 2016)

Advisory Committee on Assisted Reproductive Technology

Ms Alison Douglass (Chair)

Associate Professor Michael Legge (Deputy Chair) (resigned in June 2016)
Dr Karen Buckingham
Mr Jonathan Darby
Gillian Ferguson
Dr Kathleen Logan
Mrs Sue McKenzie
Professor John McMillan
Catherine Poutasi
Dr Barry Smith
Ms Nikki Horne (resigned December 2015)

National Ethics Advisory Committee³⁷

Victoria Hinson (Chair) (resigned in May 2016)

Associate Professor Martin Wilkinson (Deputy Chair) (resigned in June 2016)
Dr Adriana Gunder (QSM)
Dr Maureen Holdaway
Dr Julian Crane
Dr Fiona Imlach
Dr Kahu McClintock
Dr Wayne Miles
Dr Neil Pickering
Liz Richards
Dr Hope Tupara
Dr Dana Wensley
Ms Nola Dangen (term ended in October 2015)
Mr Andrew Hall (term ended in October 2015)
Dr Robert Logan (term ended in October 2015)

³⁷ The National Ethics Advisory Committee was established under s16 of the New Zealand Public Health and Disability Act 2000. As such, it does not fall under the annual report requirement in s12(5).

Appendix C:

Organisational structure

Client Insight and Analytics

Acting Chief Client Officer: Deb Struthers. The Client Insights and Analytics business unit is responsible for ensuring that all of the Ministry's clients are the focus of what the Ministry does. The business unit manages national data collections and provides evidence-based insights and analytics relating to the health and wellbeing of New Zealanders.

Finance and Performance

Chief Financial Officer: Stephen O'Keefe. The Finance and Performance business unit is the authority on the health and disability system's finance, financial and non-financial performance and risk. It is also responsible for managing and delivering the Ministry's finance functions and payments to the health and disability sector. The Finance and Performance business unit works closely with the Service Commissioning business unit supporting and advising the commissioning of services.

People and Transformation

Chief People and Transformation Officer: Stephen Barclay. The People and Transformation business unit is responsible for sector workforce and managing and delivering the Ministry's human resources and internal organisational strategy. The unit is also the business owner for the Ministry's in-house information technology strategy and leads the Ministry's change programme and operating model.

Protection, Regulation and Assurance

Director, Protection, Regulation and Assurance: Stewart Jessamine. The Protection, Regulation and Assurance business unit ensures the quality and safety of health and disability services, protects and promotes the health of New Zealanders, and provides assurance and enforcement for both regulatory and contract compliance. The business unit works closely with the Service Commissioning business unit and DHBs to ensure service quality is of a high standard.

Service Commissioning

Director, Service Commissioning: Jill Lane. The Service Commissioning business unit manages the relationships between the Ministry and health and disability service providers. This includes funding, purchasing, performance management, commercial advice and contractual arrangements. The business unit works closely with the Strategy and Policy and the Finance and Performance business units to design, plan and fund health and disability initiatives.

Strategy and Policy

Chief Strategy and Policy Officer: Hamiora Bowkett. The Strategy and Policy business unit is responsible for the Ministry's advice on the health and disability system. It develops and enables implementation of strategy and policy, including advice on Māori health, the health workforce, technology and regulation.

Technology and Digital Services

Acting Chief Technology and Digital Services Officer: Giles Southwell. The Technology and Digital Services business unit delivers technology and digital services to the Ministry and the health and disability sector. It also plays an important role in assessing the potential impact of existing and emerging health technology. The business unit works closely with the Strategy and Policy business unit, the Chief Medical Officer and the Chief Nursing Officer to develop and implement the technology and digital strategy for the health and disability sector.

Office of the Director-General

Executive Director: Jill Bond. The Office of the Director-General of Health is responsible for government and ministerial services, internal and external communications, assurance and risk management, and provides support to the Director-General of Health, Ministers and the Executive Leadership Team. The office also supports the Chief Science Officer.

Māori Leadership

Māori Leadership: Alison Thom. Māori Leadership is a strategic role that leads the Ministry and sector in reducing Māori health inequalities. It is the poutoko manawa (backbone) for the Ministry and health and disability sector in their efforts to promote, protect and partner with Māori. Māori Leadership has strong relationships within the health and disability sector and government agencies, and with iwi Māori.

Chief Nursing Officer

Chief Nursing Officer: Jane O'Malley. The Chief Nursing Officer is the point of contact for clinical leadership and advice to the Ministry, Ministers and the health and disability sector. It supports professional development within the Ministry and the nursing workforce. The Chief Nursing Officer works in partnership with the Chief Medical Officer, DHBs and clinicians.

Chief Medical Officer

Acting Chief Medical Officer: Andy Simpson. The Chief Medical Officer is the point of contact for clinical leadership and advice to the Ministry, Ministers and health and disability sector. He/she supports professional development within the Ministry and the clinical workforce. The Chief Medical Officer works in partnership with the Chief Nursing Officer, DHBs and clinicians.

Critical Projects

Director, Critical Projects: Michael Hundleby. Critical Projects oversees and manages critical priority projects on behalf of the Director-General of Health. Critical Projects has been established for a fixed term of two years.

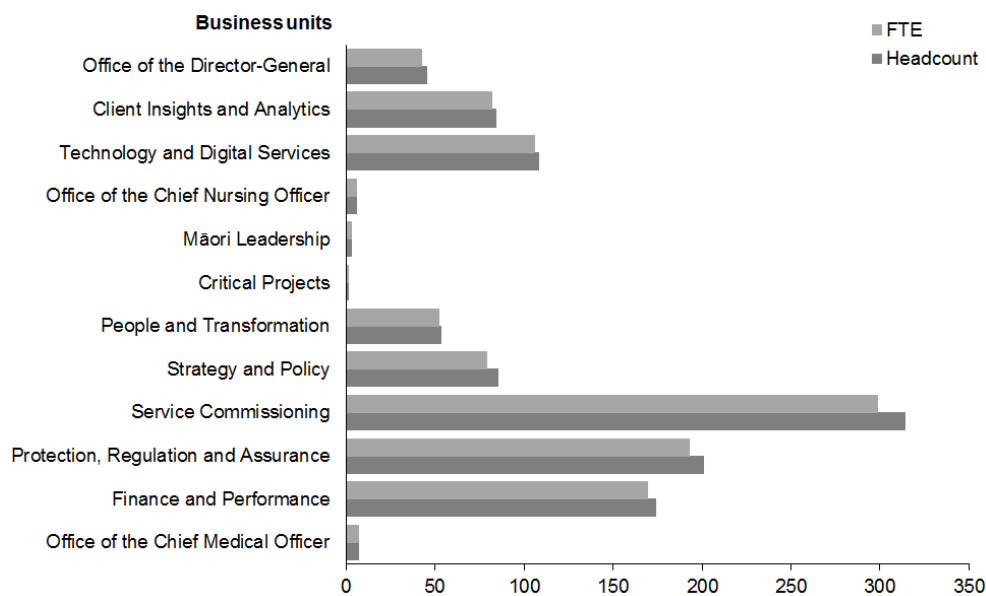
Appendix D:

Staff information

Permanent staff

The number of permanent staff at the Ministry as at 30 June 2016 was 1038.41 full-time equivalents (FTEs), or 1081 individuals.

Figure D1: Staff FTEs and headcounts, by business unit



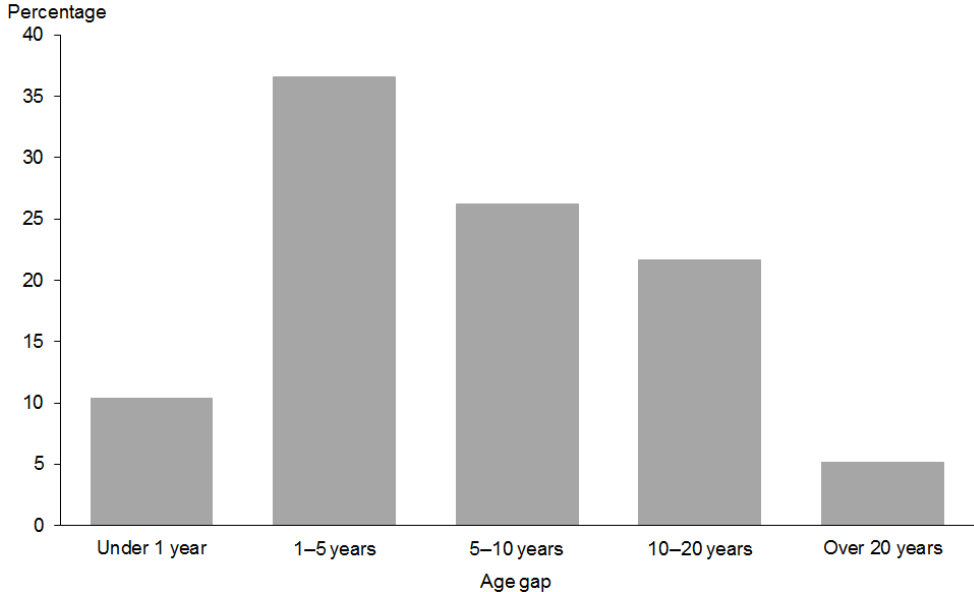
Turnover

The 12-month gross rolling average turnover rate for 2015/16 was 14.8 percent; 163 staff left the Ministry during the year.

Length of service

The average length of service for Ministry staff is seven years. Over 50 percent of current staff have been with the Ministry over five years.

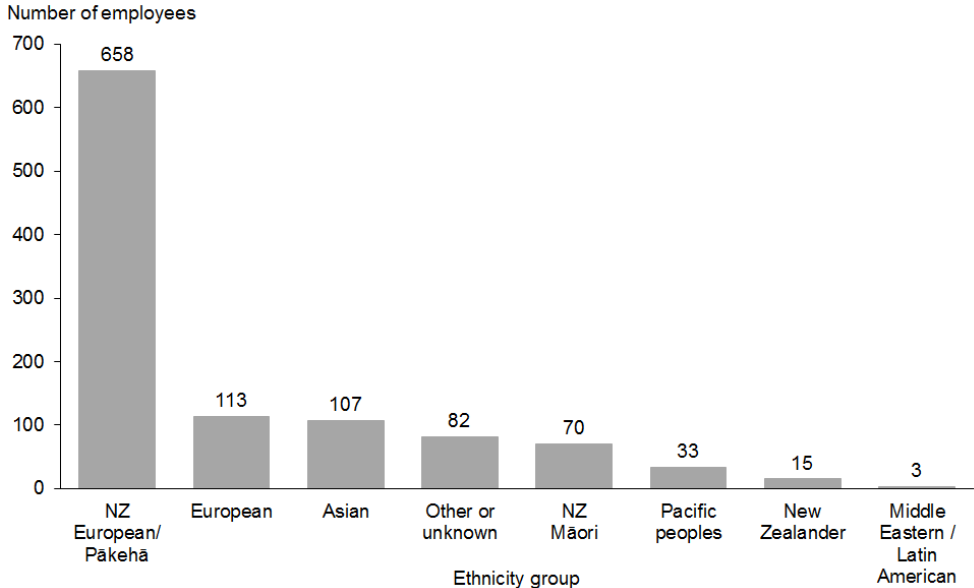
Figure D2: Staff numbers, by length of service



Ethnicity

The New Zealand European ethnic group is the most dominant group within the Ministry, at 63 percent.

Figure D3: Staff ethnicity



Gender and age

Approximately 33 percent of Ministry staff are male and 67 percent are female.

The overall average age of Ministry staff is 46 years (47 for males and 45 for females).

Figure D4: Staff numbers, by age group and gender

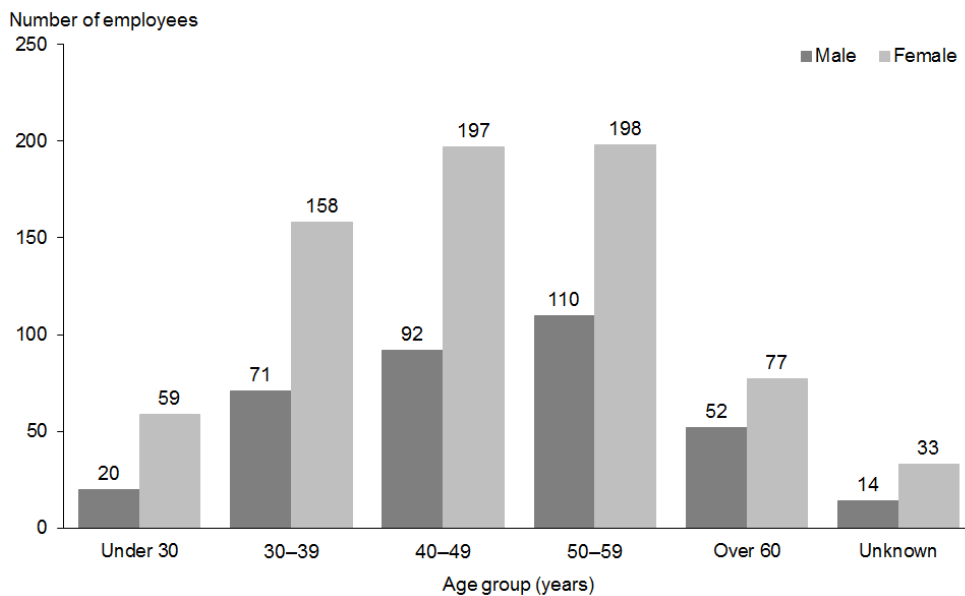
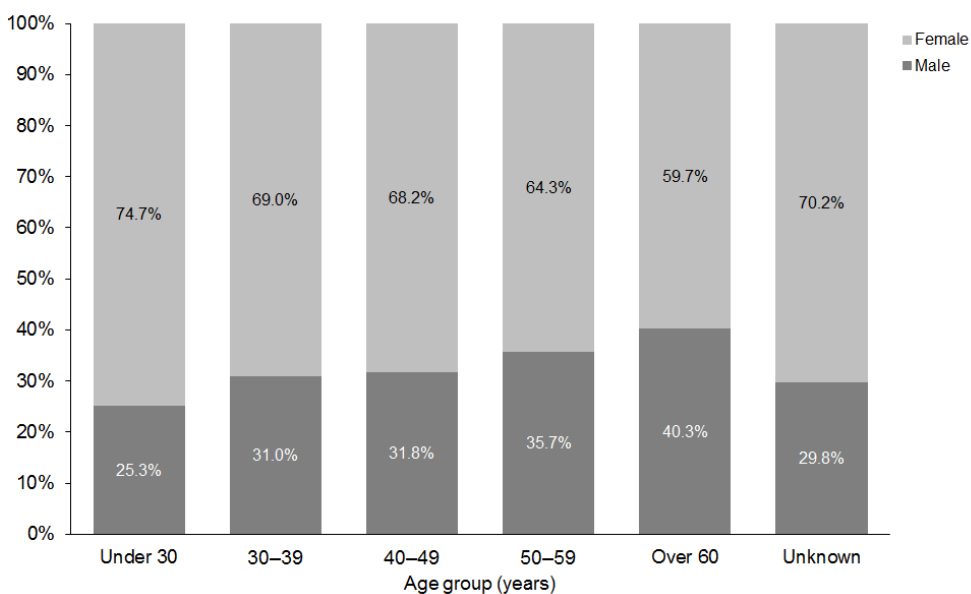


Figure D5: Gender proportion, by age group



Salary

Overall, average salaries of Ministry staff have increased since 2014/15, from approximately \$90,000 to approximately \$92,000. This is an increase of approximately 2.2 percent.

Approximately 34 percent of staff are paid over \$100,000, and there is approximately a \$16,367 difference between the average salaries paid to male and female staff (\$103,551 for male staff and \$87,184 for female staff). There are a number of potential factors relating to this difference. A major influence is that more female staff work part time.

The Ministry is an equal employment opportunity employer. The Ministry’s remuneration policy ensures that all roles in the Ministry are evaluated using a recognised methodology and that salary bands are set accordingly, ensuring all employees, regardless of their age, gender or ethnicity, are rewarded on an appropriate salary scale.

The Ministry is committed to equal employment opportunities and has a transparent system for job applications.

Figure D6: Staff numbers, by salary band

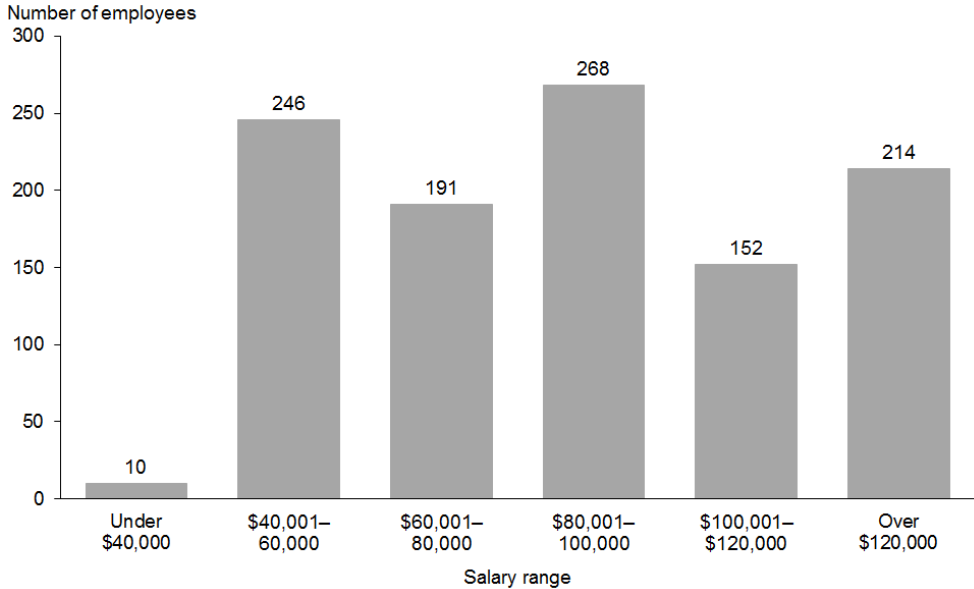
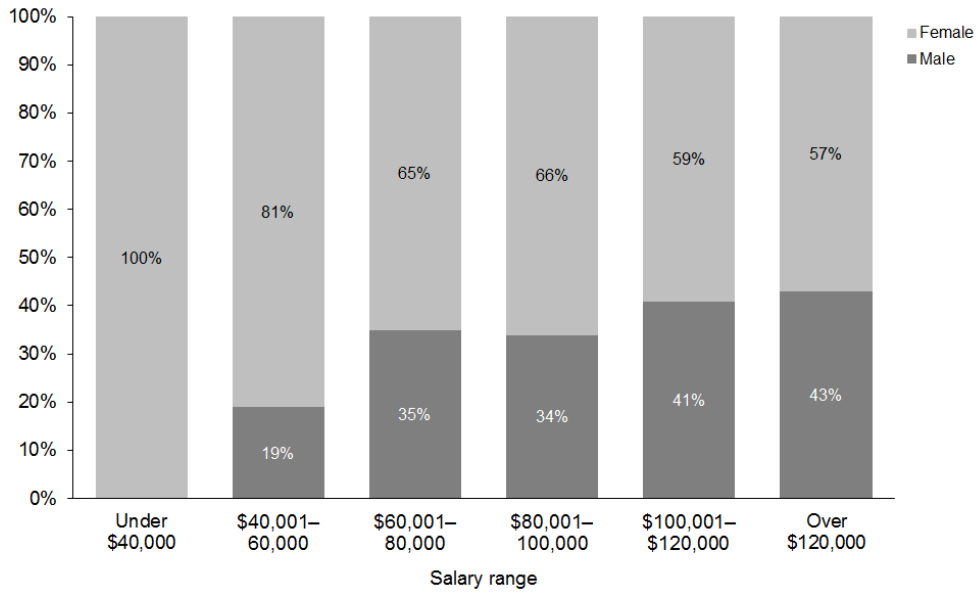


Figure D7: Gender proportion, by salary band



Appendix E: Staff location

Ministry of Health permanent staff are located throughout the country, with the highest concentration of numbers in Wellington.

Figure E1: Staff location

